MENTAL HEALTH
COMPLAINTS
COMMISSIONER

Annual Report Highlights 2018

MHCC MENTAL HEALTH COMPLAINTS COMMISSIONER

ABOUT THIS DOCUMENT

This document provides highlights of the Mental Health Complaints Commissioner's (MHCC) work in 2017–18. For more information, access the MHCC Annual Report 2018 at www.mhcc.vic.gov.au/resources/publications.

OUR ROLE AND APPROACH

The MHCC is an independent specialist statutory body established under the *Mental Health Act 2014* (the Act). A fundamental objective of the Act is to protect the rights and dignity of people accessing Victoria's public mental health services and to place them at the centre of their treatment and care. The MHCC is a key component of the safeguarding, oversight and service improvement mechanisms of the Act that were introduced to ensure the rights of people are protected and the mental health principles of the Act are upheld.

We support consumers, families and carers to raise concerns or make a complaint either directly to the service or to the MHCC. We provide accessible, tailored and flexible resolution processes that respond to the unique and diverse needs of the people who contact our office.

We make recommendations for improvements to mental health services, using our range of powers and functions under the Act to address issues of rights, quality and safety and to effect positive change. We also carry out strategic projects to identify, analyse and review quality, safety and other issues arising from complaints, enabling us to share lessons learnt for the promotion of broader system improvement.

Through our education and engagement, complaints resolution and local complaints reporting activities, we work with services to build their capacity to develop a positive complaints culture – a culture where people feel supported to raise their concerns and where services provide effective responses to complaints.

By providing avenues for people to raise their concerns, to be actively involved in resolution and decision-making processes, and to have their experiences heard and respected, we play an essential role in improving people's experiences and supporting their recovery and wellbeing.

> “Complaints represent the voices of consumers, families and carers, and our function of identifying and analysing quality and safety issues in complaints is an important way of enabling these voices to be heard and taken seriously.”

Commissioner Lynne Coulson Barr

2125
new enquiries and complaints received (see Figure 1)

1963
complaints received

337
enquiries and complaints dealt with at any one time, on average

75%
oral complaints

1990
complaints closed

RESOLVING COMPLAINTS

Of the 1,963 complaints received, 1,636 were complaints that the MHCC had authority to deal with and of these, 1,505 were able to be taken forward. We were able to achieve positive outcomes and actions by services in 96 per cent of these complaints. This was achieved either:

– through our office dealing promptly with an oral complaint to support an early response and local resolution by the service without the need for the complaint to be confirmed in writing and formally accepted by our office, or

– by the concerns being fully or partially resolved through detailed MHCC assessment and resolution processes.

Of the new enquiries and complaints made, consumers raised 1,579 (74 per cent) and family members and carers raised 440 (21 per cent). The remaining complaints were made by advocates, legal representatives, friends and staff from other services, or were referred to us from other bodies (see Figure 2).

We seek to recognise and respect the important role of families and carers in raising issues on behalf of consumers. When we accept a complaint from a family member or carer, we first seek consent from the consumer and work to involve the consumer in the resolution of the complaint whenever possible.

Figure 1

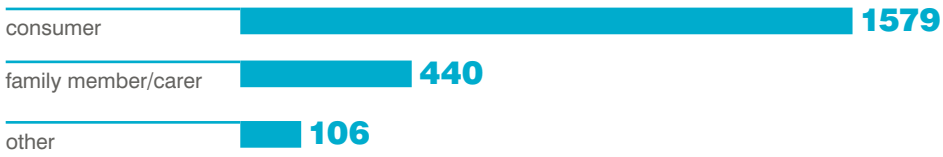
breakdown of new enquiries and complaints made to the MHCC in 2017–18 compared with 2016–17

base: all enquiries and complaints raised with the MHCC (*n* = 2,125)

Figure 2

how enquiries and complaints were raised

base: new enquiries and complaints raised with the MHCC (*n* = 2,125)



In previous years, we have described issue frequency in terms of all issues raised with our office (including enquiries and complaints that the MHCC did not have authority to deal with). This year, we have limited the analysis to complaints that represent people's experiences with mental health services over the previous 12 months to provide a more accurate and detailed picture of people's concerns and experiences. For this reason, direct comparisons with previous years have not been made in our analysis of issues raised in complaints.

Issues raised in complaints

The most common issues raised in new complaints in 2017–18 (see Figure 3) were:

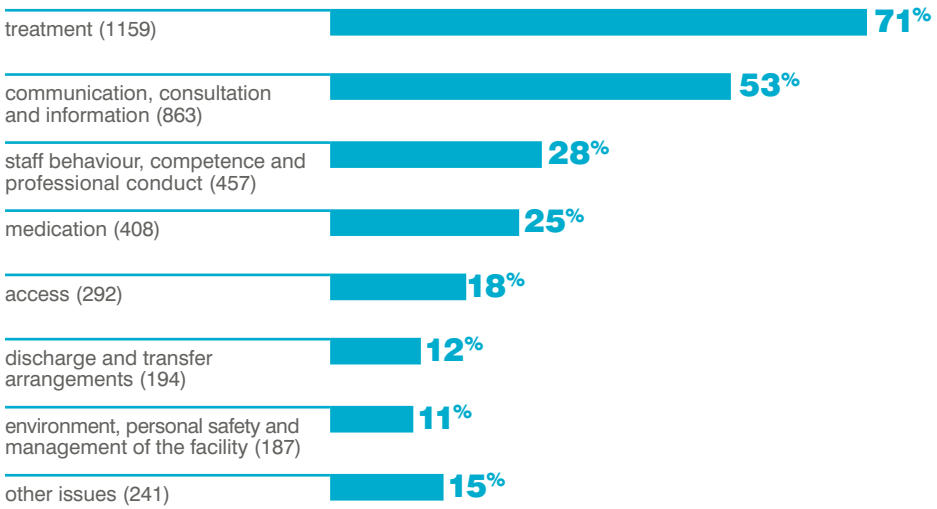
– treatment (71 per cent)
– communication, consultation and information (53 per cent)
– staff behaviour, competence and professional conduct (28 per cent)
– medication (25 per cent)
– access to services (18 per cent)
– discharge and transfer arrangements (12 per cent)
– environment, personal safety and management of the facility, which included concerns about sexual safety (11 per cent).

The common concerns raised about treatment, communication and staff behaviour are consistent with 2016–17. These concerns point to the need for services to improve the way they meet the requirements of the Act in supporting people to exercise their rights to make and participate in decisions about their treatment and care and to include support people such as family members, carers and nominated persons in this process. Effective communication is central to the implementation of supported decision making, recovery-oriented practice and recognising and respecting the role of families and carers. As part of the process of resolving complaints about communication, the MHCC encourages people who contact our office to consider the benefits of making an advance statement or appointing a nominated person.

Figure 3

main issues raised in in-scope complaints

base: frequency of issues identified in in-scope complaints raised with the MHCC (*n* = 1,636)



EXAMPLE COMPLAINT

Please note: names and some details have been omitted or changed to protect the identity of those involved.

Gabriel wrote to the MHCC expressing his concerns about his experiences in an intensive care area (high dependency unit) of a mental health inpatient unit while receiving compulsory treatment. He said he didn't think he needed to be treated in this area because he had agreed to the admission and to have treatment to help him manage his symptoms. Gabriel didn't think the service had adequately explained why he needed to be treated in the intensive care area.

Gabriel advised that he had felt unsafe in this area. He said there was a lot of noise and that he was scared for much of the time because of what was going on with other consumers. He told us that the shower wasn't working and he wasn't sure where other facilities were located, and that the call bell in his room wasn't working. Gabriel also said he had difficulties speaking to a staff member about this because they were busy assisting other people who seemed to be in greater need and he didn't want to 'get in the way'. Gabriel said he had made a complaint directly to the service about his experiences but wasn't satisfied with all aspects of their response.

When we spoke with Gabriel, we discussed our process for resolving complaints. We asked for his consent to contact the service in the first instance and to provide a copy of his written complaint to them as part of this discussion. Gabriel gave his consent for this to happen and provided a copy of the letter from the service in response to his initial complaint.

When we contacted the service to advise that we had received Gabriel's written complaint, we discussed the ways in which their initial response letter had not provided the acknowledgement that Gabriel was seeking of the distressing aspects of his treatment in the intensive care area, nor provided a meaningful explanation of the reasons why he was placed in this area. We also communicated Gabriel's desire for the service to take actions to prevent others having similar experiences to him.

Because Gabriel had moved out of the service's geographical area and was not wanting a facilitated meeting with the service to respond directly to his concerns, we requested a further written response from the service. We asked the service to explain why they had decided Gabriel should be treated in the intensive care area and to acknowledge and address Gabriel's concerns about his feelings of not being safe in this area, as well as the physical environment.

The service provided a further written response, which apologised to Gabriel for his experience and explained their process for determining that Gabriel should be treated in the high care area for the first night of his admission. Their response also explained the steps they had taken to improve their services since Gabriel's initial complaint. This included a process for checking each call bell as part of preparing a bed for a person to be admitted, a process to ensure each person in the unit knew who their nurse was for each shift and that the nurse had regular contact with them throughout the shift. Other steps they had taken included employing peer workers in the inpatient units to increase support for people during their admission, and processes to ensure debriefing for people who had experienced or witnessed distressing incidents.

The MHCC discussed the service's further response with Gabriel and the information we had sought about the improvements that had been made in response to his complaint. He said he was satisfied with the response and was pleased that his complaint had led to changes that could improve experiences for others. In closing this complaint with the service, the MHCC highlighted the importance of providing meaningful apologies, acknowledgement, answers and actions to the concerns raised by consumers about their experiences.

Undertakings and breaches of the Act

The Act enables the MHCC to use a variety of approaches to resolve complaints, depending on what is most appropriate for each complaint. Our options for dealing with complaints include accepting a formal undertaking from a service to take action, where appropriate. In situations where an undertaking is made, the Commissioner may monitor the service to assess the action taken, and issue a compliance notice if she is satisfied that the service has not complied with the undertaking. It is an offence for a service not to comply with a compliance notice. The Commissioner has promoted the option of an undertaking as an important safeguard of the Act and a way in which services can demonstrate their commitment to taking action to address identified breaches of the Act.

In 2017–18 the Commissioner accepted an undertaking from a service to take action in response to an identified breach of the Act that was acknowledged by the service, and has established a process for monitoring the agreed actions. As at 30 June 2018, the Commissioner was awaiting a response from another service to our request to provide an undertaking to an undisputed breach of the Act.

Local complaints reporting

Under the Act, all public mental health services are required to provide a twice-yearly complaints report to the MHCC specifying the number of complaints they have received and the outcomes of these complaints. We collate and analyse this data to identify quality and safety issues, and compare it with data about complaints made to the MHCC to identify key themes and emerging issues across the sector.

This year, we are reporting on a financial year rather than a calendar year for the first time in order to better align with other reporting undertaken by services. In 2017–18 we received a total of 1,702[1] reported complaints that were made directly to services, which was higher than the 1,636 complaints made to the MHCC for the same period that we have authority to deal with (see Figure 4), and represents a 27 per cent increase in the number of complaints reported by services in 2016 (1,341).

The four most common issues raised in reported complaints related to:

– staff behaviour or conduct issues (32 per cent)

– issues about the environment and management of the mental health facility (26 per cent)

– concerns about communication, consultation and information (20 per cent)

– treatment (20 per cent).

In 2017–18 we also made requests to services for additional data on reported complaints where specific risk and safeguarding issues had been raised, including in relation to sexual safety.

In early 2018–19 we will distribute individual service provider reports about 2017–18 complaints to services and make available on our website a report comparing statewide trends in MHCC and local complaints for 2017–18. We will continue to meet with services to discuss themes from these reports, work collaboratively on refining complaints reporting systems and processes, and identify and take action on areas that raise safeguarding issues.

Figure 4

number of complaints raised with service providers and the MHCC

1 Based on the 98 per cent of reports that the MHCC had received at the time of publication.

IMPROVING SERVICES AND THE MENTAL HEALTH SYSTEM AS A WHOLE

– 184 service improvements identified across 66 complaints and four investigations, more than double the number recorded in 2016–17

– 113 formal recommendations, 57 of which were made through the resolution of complaints and 56 through investigations about issues of sexual safety in acute mental health inpatient units

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When we make recommendations to services, the Chief Psychiatrist or the Secretary to the Department of Health and Human Services, we seek confirmation of actions that will or have been taken in response to the recommendations. This may include requests to services for copies of any subsequent revisions to policies or procedures. We then assess the response and, where necessary, request further information or provide advice about areas that may require further consideration.

Service improvements

Of the 184 service improvements recorded by the MHCC, most related to a review of service practices (66), changes to policies and procedures (47) and training or feedback provided to staff (46). Other improvements (25) related to changes to infrastructure, repairs or maintenance and, in two instances, identification of the need for changes to staffing profiles to respond to a particular need or to lead the implementation of systemic changes.

Practices

Changes to service practices occurred in a number of areas including:

– increased focus on identifying and responding to individual consumer needs and working with families and carers

– improvements to risk assessment and management practices

– increased involvement of on-call staff to ensure timely assessment in the emergency department

– improved practices around de-escalation and responses to people's distress

– ensuring information about rights is made available in acute inpatient units and emergency departments

– addressing access to mobile phones and personal electronic devices and upholding people's right to communicate with people outside during an inpatient admission.

Policies and procedures

Recommendations and changes to policies and procedures covered a wide range of areas including:

– improvements to discharge planning
– reviews of gender-sensitive policies and associated procedures
– review of policies and procedures associated with the use of restrictive interventions to reflect the Chief Psychiatrist guidelines
– review of admission processes for acute inpatient units to ensure any need for additional support is identified (for example, disability support)
– review of complaints policies and procedures to ensure consumers, families and carers can easily provide feedback
– development of formal processes to support and enhance the provision of shared care with private practitioners
– review of policies about supporting compulsory patients to access the Second Psychiatric Opinion Service.

Staff training

Improvements and recommendations relating to staff training included the review of, or provision of, new or additional training in:

– family-inclusive, gender-sensitive and trauma-informed practice
– identifying and responding to complaints
– rights and responsibilities under the Act
– restrictive interventions
– identifying and responding to individual needs, including physical health needs
– incident reporting requirements
– internal processes including referral and discharge processes.

Other improvements

Other improvements and recommendations included:

– escalation and rectification of maintenance issues
– adjustments to door handles in acute inpatient units
– introduction of mobile call bells for consumers
– additional beds or areas designated as women-only.

Investigations

After accepting a complaint, the MHCC has the power to conduct a formal investigation. When determining whether to investigate, we consider whether this is appropriate in light of our quality and safeguarding functions under the Act and our role in upholding people's rights and improving services. We consider the seriousness of the issues raised in the complaint and whether the person's concerns can be resolved without an investigation.

In 2017–18 we began the processes to conduct investigations into a number a matters that concern issues relating to the use of restraint and compliance with the Act, decision making on assessment orders and least restrictive options, and the assessment and management of risk of self-harm in inpatient units.

We concluded four investigations about sexual safety in acute mental health inpatient units that concerned incidents of sexual safety breaches, including suspected and alleged sexual assaults. All of these incidents had devastating impacts for the women at the centre of the complaints and their families, and raised significant issues in relation to their right to be safe during their admission.

Our recommendations in each of the investigations concern a range of issues and include:

– development and/or review of existing policies/procedures, practices and training regarding gender and sexual safety, the assessment of sexual risk and the service response to sexual safety breaches
– review of existing physical infrastructure including women-only spaces and intensive care areas and of the feasibility of introducing women-only inpatient units
– advice on how sexual safety breaches should be documented, reported, investigated and escalated within services.

In response to our findings and recommendations, we received and reviewed detailed action plans from each service to address specific issues and for broader service improvements relating to sexual safety. In 2018–19 we will continue to work with the services to explore the individual complaints resolution options that acknowledge and address the experiences and concerns raised in each complaint.

> **"[The complaints process] has provided me with a great sense of relief at the prospect that I was not only believed but taken seriously. The work that has been done and that is continuing to be done will see changes made and hopefully prevent what happened to me happening to another woman."**
>
> Consumer who participated in one of the investigations about sexual safety

> “Sexual harassment and sexual assault are violations of people’s human rights that can cause immeasurable trauma and, along with other types of sexual safety breaches, are significant avoidable harms that must be addressed.
>
> All people have the right to feel and be sexually safe when accessing acute mental health inpatient treatment, and mental health services have clear obligations to ensure a safe environment and people’s sexual safety.
>
> It is clearly unacceptable that people can become victims of sexual harassment and sexual assault, or experience other breaches of their sexual safety, during an admission to an acute mental health inpatient unit. The right to be safe report sets out the detailed recommendations on the actions required to address the significant issues identified in complaints about sexual safety breaches.”
>
> Commissioner Lynne Coulson Barr

THE MHCC’S SEXUAL SAFETY PROJECT

We commenced the MHCC Sexual Safety Project in 2016–17 to review issues of sexual safety in acute mental health inpatient environments, as part of carrying out our functions under the Act. Specifically, we sought to examine the circumstances that contribute to consumers feeling or being sexually unsafe and to consider best practice approaches for ensuring sexual safety.

Over our first three years of operation, we identified concerning themes in complaints about sexual safety in mental health services. These included complaints about people not feeling or being sexually safe or experiencing sexual activity, sexual harassment or alleged sexual assault in acute inpatient environments. The gravity of many of the issues raised and the variability in service responses indicated a need for closer examination of these issues to identify ways to prevent these significant avoidable harms.

The project examined data from 90 complaints made to the MHCC and reported by services, and findings from four MHCC investigations. It was also informed by a national and international literature review and stakeholder consultations. The data analysis revealed that the majority of complaints related to breaches of women’s sexual safety by male co-consumers, and that there were a number of risks in acute mental health inpatient units, particularly in intensive care areas, that need to be addressed to uphold all people’s right to safety in these environments.

Our project findings and the recommendations made to the Department of Health and Human Services, the Chief Psychiatrist and mental health services are detailed in the project report, *The right to be safe*, which we launched at our inaugural learning from complaints forum in March 2018. On the day, attendees from across the sector came together to consider our recommendations relating to practices, guidelines, infrastructure, training and culture, and to explore the range of perspectives and partnerships required to address this significant avoidable harm.

Recommendations for ensuring sexual safety

In *The right to be safe* report we identified the need for sexual safety to be recognised as a human rights issue and to receive priority attention in accordance with Victoria’s broader violence prevention strategies.

For the full project recommendations to the department, the Chief Psychiatrist and mental health services, access *The right to be safe* report at www.mhcc.vic.gov.au/resources/publications.

Overall recommendation: That the department develops a comprehensive sexual safety strategy to plan, coordinate and monitor action to prevent and respond to breaches of sexual safety in acute mental health inpatient units.

This strategy needs to be underpinned by a clear policy directive for mental health services on requirements and actions to ensure sexual safety. It needs to reflect the principles of human rights, violence prevention, trauma-informed care, recognising and responding to diversity and working with people with lived experience in developing approaches to support people to be and feel safe when accessing acute mental health inpatient treatment.

In response to *The right to be safe* report, the department has agreed to develop a comprehensive sexual safety strategy that responds to the recommendations, and to drive an implementation plan to ensure a continued and sustained commitment across all mental health services (for the department's full response, see page 9 of *The right to be safe* report).

Our follow-up to *The right to be safe*

We have been engaging with the department, the Chief Psychiatrist and mental health services to further our understanding of their responses to the recommendations and to discuss the actions that are being taken to ensure sexual safety. Our team has also been engaging with consumer and carer organisations and networks on the implications of the report's findings. Our planned activities include furthering these discussions, as well as:

– delivering training sessions to mental health service staff on ensuring sexual safety
– continuing to develop the MHCC's approaches to addressing sexual safety issues identified in complaints
– including the report's findings and recommendations in materials used to support our work in education and engagement, and contributions to consultations and submissions relating to broader areas of service and system improvement
– seeking formal responses from the department, the Chief Psychiatrist and mental health services on the actions that have been taken and planned to respond to the report's recommendations.

We will continue our discussions on ways to address and prevent these significant avoidable harms in Victoria's acute mental health inpatient units in 2018–19.

> "In this report we have endeavoured to honour the preparedness of people to make complaints about extremely distressing and devastating experiences and allegations of sexual harassment, sexual assault and incidents of sexual activity in inpatient units, and their want for actions to be taken to prevent other people from having similar experiences."
> Commissioner Lynne Coulson Barr

Download your copy of *The right to be safe* report at www.mhcc.vic.gov.au/resources/publications.

REPORTING ON RESPONSES TO OUR RECOMMENDATIONS

We continued to work closely with the department in relation to recommendations made in previous years and are pleased that progress has been made in all areas, as summarised below:

Recommendation: That the department develops policy and practice guidance on access to mobile phones and other communication devices for consumers during inpatient admissions.

Response: The Chief Psychiatrist has advised that his office is developing a guideline that seeks to address issues around the use of electronic devices for communication in Victorian designated mental health services.

Recommendation: That the department reviews the program guideline used by health services to charge fees for secure extended care unit (SECU) patients and develop a policy that is consistent with the Act and contemporary practice in healthcare settings.

Response: The department has advised that guidance will be provided to area mental health services on the policy and fees that can be charged for inpatients in Victorian public hospitals.

Recommendation: That the department reviews reporting requirements for restrictive interventions as they relate to emergency departments.

Response: The department has confirmed that the use of restrictive interventions in emergency departments must follow both the legal requirements of the Act and best practice requirements stipulated in the Chief Psychiatrist's guideline.

Recommendation: That the department considers and addresses the categorisation and notification of incidents of alleged 'staff to client' assaults in designated mental health services.

Response: The department has advised that this recommendation will be addressed through work being undertaken on the Victorian Health Incident Management System (VHIMS) Central Solution, and that the Office of the Chief Psychiatrist will implement a notification solution for mental health that mirrors the way in which the Chief Psychiatrist is notified of reportable deaths.

Recommendation: That the department considers and addresses the need to develop guidelines and requirements for investigations which are applicable for designated mental health services.

Response: The department has advised that this recommendation will be addressed as part of the response to *The right to be safe* report.

Recommendation: That the department includes policy and practice guidance for designated mental health services engaging with Victoria Police and processes for reporting crimes in the protocols and guidance paper currently being prepared in collaboration with Victoria Police.

Response: The department has advised that this recommendation will be addressed as part of the response to *The right to be safe* report.

Recommendation: That the department considers and addresses the need for specific policies, practice guidance and training for mental health staff in relation to the needs of people with a dual disability.

Response: The department has advised that a strategy is being developed to inform the resources and tools needed to support specialist mental health services in assessing and managing people with a dual disability who access the mental health system.

Recommendation: That the department considers the need for the development of clinical guidelines for the management of shared care arrangements with private medical practitioners.

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19.

Recommendation: That the department considers setting standards and guidelines for the development of mental health service's outdoor spaces that provide a pleasant and therapeutic environment while also ensuring the safety of consumers.

Response: Courtyards and outdoor spaces in Victoria's mental health units were reviewed by the department in 2017–18, and Australia's national mental health facility guideline (HPU 131 Mental Health) was updated and released on 14 March 2018.

Recommendation: That the department considers reviewing and expanding the discharge planning guideline to address the need for effective communication and engagement with consumers, families and carers in discharge planning.

Response: The department has advised that work on updating the Chief Psychiatrist's *Discharge planning guidelines* is almost complete. The MHCC has contributed to this work by providing data and analysis of the volume and nature of issues relating to discharge planning that have been raised in complaints made to our office.

STRENGTHENING EDUCATION AND ENGAGEMENT WITH THE SECTOR

– 1,929 consumers, family members, carers, service staff and other stakeholders reached through our education and engagement activities

– 60 direct education and engagement activities including presentations, training sessions and other activities

– 51 other stakeholder meetings and events

Review of our education and engagement strategies

In 2017–18 we started a process to map and review the work that is undertaken across our office, with a view to assessing the extent to which we currently inform, engage, involve and collaborate with consumers, families, carers, services and other stakeholders, and where we can improve. This process will help us to prioritise key areas of our work, clarify what we want to achieve, and develop and implement targeted and effective strategies for increasing our level of engagement with key stakeholders.

Of particular note is our most recent initiative to ensure productive working relationships with clinical mental health services through regular meetings. These meetings allow discussion about trends and quality and safety issues identified in complaints to the MHCC and in local complaints reporting data. These meetings have focused on supporting approaches to local resolution of complaints, review of complaints policies and procedures, and the use of information from complaints to inform service improvements.

Membership to the MHCC Advisory Council provides opportunities for people with lived experience as consumers, families and carers, and people working in services, to take part in and shape our work. In 2017–18 the council's contributions included:

– **having input into key strategic projects, including the scoping for an MHCC project on developing a lived experience framework to inform and drive the work that is undertaken across our office, and articulate the ways in which the principles of co-design and co-production apply to our work**

– **providing feedback on our education and engagement initiatives and materials**

– **participating in discussions on our business planning, including in relation to priority areas for 2018–19**

– **delivering a training session to MHCC staff on the role of supported decision making in protecting people's rights and ensuring choice.**

Promoting awareness and accessibility

In 2017–18 we continued to promote awareness of ways to raise complaints and the role of complaints in improving people's experiences. We achieved this through direct education and engagement activities, as well as through our MHCC News e-bulletin, website news stories, information products and regular posts across our Facebook, Twitter and LinkedIn sites.

We also worked on improving our accessibility and responsiveness to priority population groups, recognising that people within these groups may experience particular barriers and challenges in raising concerns about their experience with mental health services.

In 2017–18 we delivered a wide range of education and engagement activities for consumers, family members, carers, service staff and other stakeholders including:

– 22 education sessions reaching 1,295 people

– 11 service visits and meetings

– 23 consumer and carer engagements reaching 494 people

– 6 articles published in mental health journals and health publications

– 4,300 social media followers and 34,426 hits to the MHCC website.

Our education and engagement highlights from 2017–18 include:

- **launching the new MHCC website, which offers a broad range of inclusive resources on our role and people's rights under the Act, an easy-to-navigate online complaints form and new webpages in 15 languages for Victorians from culturally and linguistically diverse communities**
- **presentations at national conferences and forums, including at The Mental Health Services (TheMHS) Conference, the Australian Rural and Remote Mental Health Symposium and Victorian conferences hosted by the Victorian Mental Illness Awareness Council, Tandem Carers and Mind Australia**
- **developing and promoting an information sheet to ensure Aboriginal people in Victoria have access to culturally appropriate and engaging information about their rights under the Act and how to make a complaint.**

For more information, access the MHCC Annual Report 2018 at **www.mhcc.vic.gov.au/resources/publications**.

The MHCC's Aboriginal artwork created by Marcus Lee Design.

MHCC
MENTAL HEALTH COMPLAINTS COMMISSIONER

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SPEAK UP.

YOUR EXPERIENCE MATTERS.

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We welcome your feedback about your experience with us or any aspect of our work.

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