
Everyone's experience matters

Mental Health Complaints
Commissioner
Annual Report 2019





7 August 2019

The Hon Martin Foley, MP
Minister for Mental Health
Level 22, 50 Lonsdale Street
Melbourne 3000

Dear Minister,

I am pleased to provide you with the annual report of the Mental Health Complaints Commissioner for the financial year 2018–19.

As required under s 268 of the Victorian *Mental Health Act 2014*, the report describes our activities for the year including the number of complaints made to the Commissioner, the outcomes of these complaints and our education activities.

I trust our annual report will help to inform the parliament, consumers, families, carers, mental health services and the wider Victorian community about our key safeguarding, oversight and service improvement roles under the Act.

Yours sincerely

Dr Lynne Coulson Barr
Mental Health Complaints Commissioner

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Commissioner's message



Everyone's experience matters

The MHCC's key messages, *'Speak up. Your experience matters'* and *'Speaking up improves services for you and for other people'* are as important now as they were in our first year of operation. Five years after our establishment, many consumers, families and carers still face barriers and some feel fearful about making a complaint. Given that up to 40 per cent of all people accessing public mental health services each year are doing so for the first time, the MHCC, mental health services and advocacy and support organisations all have a vital role to play in ensuring that people feel safe and supported to speak up. Some members of our community face additional barriers to making a complaint, so we continue to work to ensure that we are accessible, inclusive and culturally safe for all Victorians, including older and young people, Aboriginal Victorians, LGBTIQ+ and culturally diverse communities, and people with disabilities.

This year, the MHCC welcomed the Victorian Government's decision to establish a Royal Commission into Victoria's Mental Health System. This is a once in a generation opportunity to re-imagine and reform our mental health system and deliver services that are truly person-centred, rights-based and recovery-oriented. There are many lessons to be learned from people's experiences of the mental health system. Our submission to the Royal Commission drew directly on the experiences, insights, and views of the people who have spoken up in the over 16,000

complaints made or reported to our office over our first five years of operation. We also drew on our work with services which provides a window into the challenging environments and circumstances in which staff work, including managing the high demand for services, resource constraints and outdated infrastructure and models of care.

As the Royal Commission has also heard, consumers, families and carers can experience significant challenges in their interactions with mental health services. As in previous years, the themes identified from complaints made to our office and reported by services tell us that much more needs to be done to ensure consumers are safe, and that they are supported to make or participate in decisions about their care and treatment. In the gravest instances, some people experience significant harm when accessing treatment, with lasting (in some instances life-altering) negative impacts on their health and wellbeing.

Many incidences of significant avoidable harms and trauma have been identified in complaints to the MHCC, some highlighted in our 2018 *The right to be safe* report, which point to the need for concerted actions that will prevent such harms from reoccurring. We also observe a continuing need for recovery-oriented practice, supported decision making and trauma-informed care to be truly embedded in service provision, and for there to be a greater understanding of the role of family members, carers and other support people in the recovery and wellbeing of consumers.

As well as the significant trauma that people can experience while seeking treatment in mental health services, negative experiences of services or unresolved issues about an experience of treatment can create real barriers to people's recovery and willingness to engage with services in future.

On the other hand, positive resolution of complaints to the MHCC and to services can make a powerful difference to people's wellbeing, recovery and future engagement with services. Engaging meaningfully and respectfully with people about their concerns can be critical for addressing the impacts of their experiences and enabling people to move forward. People can also benefit from knowing their complaints can create lasting change to Victorian mental health services and prevent other people from having similar experiences. Over the past year, for example, the MHCC made 77 recommendations for service improvements and recorded 88 service improvement actions arising from complaints, many of which were proactively initiated by services after receiving a complaint. Each of these changes can have a powerful impact on people's experiences of mental health treatment and recovery.

We welcomed the Victorian Government's allocation of additional funding to the MHCC for 2019–20 and 2020–21 in its last budget, which will increase our capacity to perform our safeguarding, oversight and service improvement functions, and to respond to the growing volume and complexity of complaints made to our office. Increased resources will enable us to undertake more investigations, identify more quality and safety issues in complaints and generally respond better to demands. We also plan to renew our education and engagement efforts to build the capacity of services to effectively respond to complaints and to ensure that all people accessing Victorian public mental health services are aware of their right to make a complaint and feel safe and supported in doing so.

I give special thanks to the MHCC staff for the skill, care and commitment they bring to the important work of our office. Each day we bear witness to the grave and distressing nature of people's experiences, and the importance of ensuring that they feel heard, respected and supported when raising their concerns. We acknowledge the support of consumer, carer and advocacy organisations in assisting people to make a complaint, and the ways in which service staff work with us to achieve positive outcomes from complaints.

I also thank the members of the MHCC Advisory Council, under the leadership of Chair Dr Anthony Stratford, for their commitment and service as the Council enters its fourth year. Each member continues to contribute their experiential wisdom, invaluable insights and knowledge of mental health service provision. It is the voices of people and their support networks that inform our strategic directions and shape our work.

I thank the Hon. Martin Foley, Minister for Mental Health, and the Secretary of DHHS for their strong support and commitment to the role of our office. I also acknowledge the departmental officers who support our operations, the Office of the Chief Psychiatrist, clinical and executive directors of services, our colleagues in other statutory bodies and the many committed community members and consumer and carer organisations that share our goal of improving people's experiences and services.

Over the coming year, we will continue to highlight areas that require attention to safeguard people's rights, embed the principles of the *Mental Health Act 2014* and improve the quality and safety of services. We are committed to contributing these insights to the Royal Commission as it formulates its recommendations for broad scale reforms of the mental health system, and ensuring that *everyone's experience matters*.

Dr Lynne Coulson Barr

Year at a glance

Complaint numbers and outcomes

2195

new enquiries and complaints

2495

total enquiries and complaints dealt with

319

matters open on average at any one time

91%

of complaints had positive outcomes and actions for consumers, families and carers either through being fully or partially resolved by the MHCC or the MHCC assisting in direct resolution of complaints with services

100%

of services provided local complaints reports

1854

in-scope complaints reported by public mental health services

167

Actions to improve services including:

88

service improvements

77

recommendations to mental health service providers, the Chief Psychiatrist or Department of Health and Human Services

2

formal undertakings from services to take specific actions in response to complaints.

Education and engagement activities

2542

people reached, including consumers, families, carers, service staff and other stakeholders

83

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

6991

information products distributed

4881

social media followers across Facebook, Twitter and LinkedIn

38440

views of our website

Service and system contributions

32

contributions to sector consultations, projects, submissions and formal feedback

7

memberships of advisory and reference groups

22

sector events attended

51

additional stakeholder meetings and events attended



About the MHCC

A note on language

The MHCC recognises that people with lived experience of mental health issues use various terms to describe themselves. Feedback from consumers, families, carers and service staff guides our use of language in our communications, including our annual reports.

We use person-centred, recovery-oriented, inclusive language wherever possible. At times throughout this report we use words and terms consistent with the *Mental Health Act 2014* to ensure accuracy of meaning. For definitions of frequently used words, see the glossary in Appendix 1.

The Mental Health Complaints Commissioner (MHCC) is an independent specialist body established under the *Mental Health Act 2014* (the Act) to safeguard people's rights, resolve complaints about Victoria's public mental health services and recommend service and system improvements. We work collaboratively to resolve complaints in ways that support people's recovery and wellbeing and improve the safety and quality of mental health services for all Victorians.

Our vision is a public mental health system that welcomes and learns from complaints, makes quality and safety improvements to protect the rights of consumers, families and carers, and upholds the principles of the Act in all aspects of service delivery.

Our broad powers enable us to deal with complaints about designated mental health services and publicly funded mental health community support services (MHCSS). Historically, this has included complaints about the funded psychosocial supports provided by MHCSS under the National Disability Insurance Scheme (NDIS). However, this role will transition to the NDIS Quality and Safeguards Commission from 1 July 2019.

Our role

A fundamental objective of the Act is to protect the rights and dignity of people accessing 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 people to speak up about their experiences and to make complaints either directly to the mental health service or to our office. We then work with people in a flexible way that meets their diverse individual needs. We assess and resolve every complaint through the lens of the Act and its principles in ways that:

- **safeguard rights**, promoting awareness of people's rights and compliance with the Act and the *Victorian Charter of Human Rights and Responsibilities Act 2006*
- **support recovery**, ensuring people are heard and respected and feel confident that their views and preferences have been appropriately considered
- **improve services**, ensuring compliance with the Act and identifying opportunities to improve services
- **improve individual experiences**, providing a person-centred process that works to reduce fears and build the confidence and relationships needed for a person to raise concerns directly with the service
- **aim to prevent a recurrence of issues**, both for the individual concerned and for others.

As outlined in the safeguarding rights section of this report (pages 12–31), the MHCC can make recommendations for service and system improvements and use our range of powers and functions under the Act to effect positive service change and to promote and protect the rights of consumers. This includes formally investigating matters involving risk and safeguarding concerns identified in complaints, and can include seeking undertakings from services to take remedial action to address identified breaches of the Act or serious concerns about the lawfulness of service actions, and report back on them. Under the Act, the Commissioner may issue a compliance notice for the undertaking if necessary. It is an offence for the service not to comply with this notice.

We also carry out strategic projects under our function to identify, analyse and review quality, safety and other issues arising from complaints. This means we can share the lessons learnt through complaints and investigations to promote broader system improvement and ensure rights are promoted and protected.

As an additional oversight, all public mental health services are required under the Act to provide a twice-yearly report to our office detailing the number of complaints made directly to their service and the outcomes of these complaints. We analyse this data and work with services to address the issues identified.

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. This is a culture where people feel supported to raise their concerns and where services provide effective responses to complaints and initiate service improvements where identified.

5 years of learning from complaints

Over our five years of operation we have garnered critical information to drive systemic improvements from the over 16,000 enquiries and complaints made by consumers, families, carers, advocates and others. This includes 9,261 enquiries and complaints made to the MHCC and over 7,000 complaints reported by services through the Act’s local complaint reporting requirements.

From the issues identified through complaints, we have made over 250 recommendations and complaints have resulted in nearly 500 service and system improvements either identified by services or resulting from discussions between the person making the complaint, the MHCC and services through the resolution process. In addition, we have obtained three legal undertakings from services (more currently being negotiated) as outlined in ‘Safeguarding rights and resolving complaints’ (page 12).

Mental Health Act – our functions

The Mental Health Act gives the MHCC the following key functions (s 228):

- (a) to accept, assess, manage and investigate complaints relating to public mental health services
- (b) to endeavour to resolve complaints in a timely manner using formal and informal dispute resolution (including conciliation), as appropriate
- (c) to provide advice on any matter relating to a complaint
- (d) to make the procedure for making complaints in relation to services available and accessible, including publishing material about the complaints procedure
- (e) to provide information, education and advice to services about their responsibilities in managing complaints
- (f) to assist consumers and people acting on behalf of, or who have a genuine interest in the wellbeing of, consumers to resolve complaints directly with the service, either before or after the Commissioner accepts the complaint
- (g) to assist services in improving policies and procedures for resolving complaints
- (h) to identify, analyse and review quality, safety and other issues arising from complaints and make recommendations for improvements to services, the Chief Psychiatrist, the Secretary to the Department of Health and Human Services (DHHS) and the Minister for Mental Health¹
- (i) to investigate and report on any matter relating to services at the request of the Minister.

¹ This subsection has been amended with effect from 1 July 2019 to include recommendations to the NDIA and the NDIS Quality and Safeguards Commission.

Mental health principles (s 11, Mental Health Act)

a Provide least restrictive treatment

Persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible, with voluntary assessment and treatment preferred.

b Promote recovery

Persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.

c Ensure supported decision making

Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.

d Support decisions involving risk

Persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk.

e Promote rights, dignity and autonomy

Persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.

f Recognise and respond to medical needs

Persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.

g Recognise and respond to individual needs

Persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.

h Recognise and respond to Aboriginal culture and identity

Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to.

i Promote the best interests of children and young people

Children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible.

j Protect children and young people

Children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected.

k Involve carers

Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.

l Recognise, respect and support carers

Carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.

Advisory Council

The Advisory Council is ‘live’ and the experiences of council members are actively sought to drive and strengthen the depth of the work done by the MHCC.

Dr Anthony Stratford, Chair

The MHCC’s Advisory Council is made up of 11 people who draw on their unique personal and professional expertise and experiences to provide us with strategic advice and insight, collaborating on our projects and informing changes to our practice.

The Advisory Council is one of the main ways we make sure our work is informed and driven by people with lived experience as consumers, families, support people and carers, or who work in mental health services. In 2018–19 the Advisory Council’s focus has been on working with the lived experience project team (led by the Senior Advisor, Lived Experience and Education) to develop a framework for how the lived experience of consumers and carers informs and drives our work. This project has been guided by the principles of co-production and co-design.

Some examples of the Advisory Council’s contributions to the MHCC’s work are featured throughout this report.

Members

The Advisory Council’s members are people of different ages, cultural and linguistic backgrounds and gender and sexual identities. Included are:

- five people with lived experience as consumers, including the chair
- three people with lived experience as family members and/or carers
- three people with experience of working in mental health services.

The MHCC Advisory Council is chaired by Dr Anthony Stratford.

This year, the council accepted the resignations of Rachael Lovelock and Associate Professor Steven Moylan. We thank both of them for their valuable contributions during the term of their appointments. In 2018 we were pleased to welcome new members Dr Michelle Knuckey and Debbie Prout, who have experience working in child and youth mental health services, and Violeta Peterson, who has been both a carer and a carer consultant working in mental health services.

In 2018–19 we created the role of Associate Member so we can be informed by a broader range of experiences and perspectives. Associate Members contribute to MHCC working groups and specific projects and undertake other tasks requested by the Advisory Council. In the coming year we will be looking at ways to expand the role and contributions of Associate Members to support the implementation of the lived experience framework.

As at 30 June 2019, Advisory Council members were:

- Dr Anthony Stratford (chair)
- Christine Abdelmalek
- Robyn Callaghan
- Hanna Jewell
- Simon Katterl
- Dr Michelle Knuckey
- Annette Mercuri
- Violeta Peterson
- Debbie Prout
- Gloria Sleaby
- Tom Wood.



Safeguarding rights and resolving complaints

Safeguarding people’s rights through complaint resolution

A rights-based approach to complaints resolution means that we:

- assess all complaints against the requirements of the Act, the Charter and relevant standards and guidelines
- immediately escalate complaints raising urgent concerns about people’s rights or safety issues to ensure action is taken
- support people who contact us to understand and exercise their rights under the Act and through our complaints processes and to self-advocate and access support
- identify areas where rights are not being adequately promoted and protected and ensure action is taken to address this
- hold services accountable for promoting and protecting the rights of consumers (for example, through seeking enforceable undertakings where a breach of a person’s rights or the requirements of the Act has occurred – see page 13)
- make recommendations to improve the mental health service system based on what we learn through complaints.

A function of the MHCC under the Mental Health Act is to identify, analyse and review quality, safety and other issues arising from complaints about mental health services, and to make recommendations to improve them. In carrying out this function, we ensure that the rights of people accessing mental health services are upheld and promoted, and that their experiences, views and feedback inform and influence practice within mental health services.

The requirements, rights and mental health principles of the Act as well as the rights contained in the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter) are the foundation of our approach to resolving complaints.

As well as assessing mental health service responses to complaints against the requirements of the Act, the Charter and relevant guidelines and standards, we consider the views and preferences of the consumer, and their support people, who are at the centre of the complaint. We draw on all this information to identify ways to resolve complaints and make recommendations to services that ensure people’s rights are respected and promoted.

Our analysis of complaints involving rights and safety issues guides our strategic work and informs our input into the work of other organisations. We share the insights and knowledge gained through complaints to us and work collaboratively with services, the Chief Psychiatrist, DHHS and other relevant statutory bodies. This information informs our shared goal of ensuring safe, high-quality mental health services.

Our approach

The MHCC uses a variety of approaches in resolving complaints, depending on what is most appropriate in the circumstances. Our options for dealing with complaints include:

- assisting people to raise their concerns directly with the mental health service
- using informal and formal dispute resolution processes such as reviewing service responses, facilitating meetings between the service and the person and seeking and confirming actions to address identified issues
- providing advice and recommendations to services
- referring the complaint to conciliation
- investigating matters, seeking formal undertakings from services and issuing compliance notices where appropriate.

Risk and safeguarding issues

For all complaints, the MHCC assesses service practices against the requirements and principles of the Act, the National Standards for Mental Health Services, the National Safety and Quality Health Service Standards, Chief Psychiatrist guidelines and other relevant standards and guidelines.

When assessing complaints involving risk and safeguarding issues, we may review relevant documents including incident reports, clinical records, relevant policies/guidelines and the reports of investigations or incident reviews conducted by the service or external investigators.

We seek to understand what has occurred, how it has occurred, and how similar incidents can be prevented in the future for the affected individual and for others. Through this process, we also aim to increase the ability of services to identify critical safeguarding issues themselves and to act proactively to uphold consumers’ rights.

When assessing service responses to complaints, we seek input from the consumer, as well as their family, carers and other supports as appropriate, to ensure their concerns are resolved and that the service has fulfilled its responsibilities under the Act and the Act’s mental health principles.

Outcomes of complaints involving risk and safeguarding issues may include making formal recommendations to the service to change or improve practice, processes or training. In some circumstances, we use other options such as conducting an investigation or seeking an undertaking.

Undertakings and breaches of the Act

One of the Commissioner’s options for dealing with complaints is to accept a formal undertaking from a mental health service to take a specific action or actions. Undertakings are used in many regulatory settings to promote compliance with laws and requirements without the need for court proceedings.

An undertaking is legally enforceable and the Commissioner can 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.

In 2018–19 the Commissioner accepted two undertakings from services and was in the process of negotiating the terms of a further three as at 30 June 2019. Three undertakings related to acknowledged breaches of the Act – one was about the provisions for making an assessment order, and two concerned the legislative requirements for using bodily restraint.

One undertaking finalised in 2018–19 was in response to serious allegations of verbal and physical abuse and neglect of residents of a mental health service. Another undertaking currently being negotiated relates to a case where the Commissioner has serious concerns about the lawfulness of staff actions.

These cases also raise issues of whether services have complied with the Charter and their obligation to have regard to the mental health principles of the Act.

A common feature of most undertakings is the service being required to conduct an audit of its compliance with the relevant provisions of the Act or with the Chief Psychiatrist’s guidelines. The service then reports the outcome of the audit to its clinical governance committee and to the Commissioner. Undertakings commonly also include actions amending policies and procedures and staff training. The Commissioner monitors and reviews the action taken in response to the undertaking.

Undertakings are signed by the chief executive officer of the service and must be implemented by senior management as part of the service’s clinical and corporate governance responsibilities. Undertakings are an effective option for promoting long-term change and strengthening a rights-driven culture in the mental health system.

Overview of complaints to the MHCC

In 2018–19 more people contacted the MHCC to raise concerns or queries about their experiences than in any previous year. We received 2,195 new enquiries and complaints, comprising 1,976 complaints and 219 enquiries. The number of new enquiries and complaints has continued to increase each year even though we have had to limit our promotional and education activities to manage the volume of resolutions work within our available staffing resources.

Of the 1,976 complaints received in 2018–19, 1,508 were about people’s recent experiences in Victorian public mental health services (known as in-scope complaints) (see Figure 1). The MHCC received a higher number of complaints that were not about a public mental health service than in previous years. This increase appears to be attributable to more people being prompted by the media coverage of the Royal Commission into Victoria’s Mental Health System to make a complaint about their experiences with the broader mental health system.

Complaints that were not about Victorian public mental health services were most commonly about general health services, private practitioners working in mental health, or mental health services in other jurisdictions. When we receive these complaints, we help people to identify options for resolving their concerns, including supporting them to contact the most appropriate body.

Including the complaints that were carried forward from 2017–18 (300), the MHCC dealt with 1,808 in-scope complaints and 2,495 enquiries and complaints in 2018–19, a small increase on the 2,448 matters dealt with in 2017–18. Figure 2 shows the continuing increase in total enquiries and complaints dealt with from the MHCC’s commencement in 2014–15 to 2018–19.

On average, 319 matters were open at any one time in 2018–19.

Figure 1
breakdown of all complaints and in-scope complaints in 2018–19

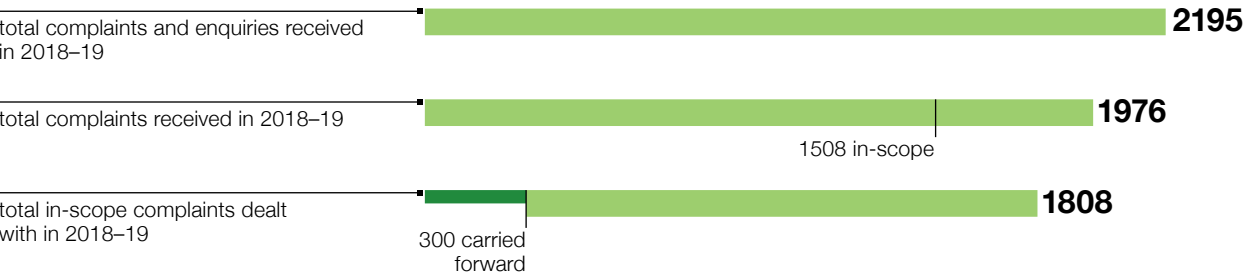
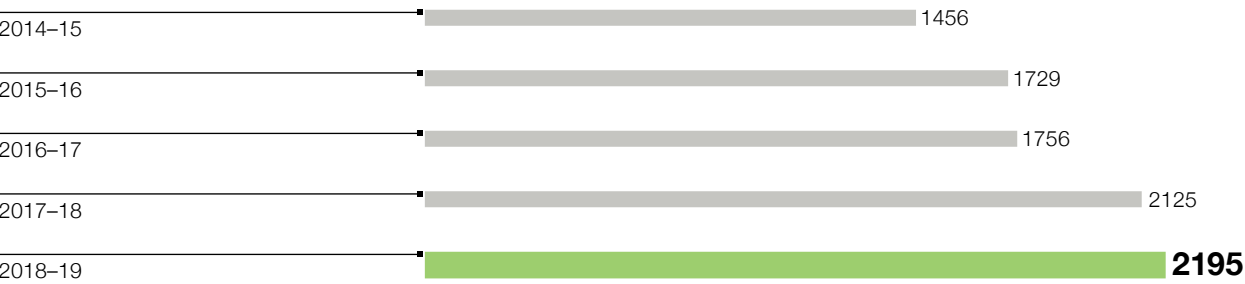


Figure 2
year-on-year comparison of total enquiries and complaints



Definition of enquiry

An enquiry is a request for information, advice or assistance. Enquiries to the MHCC can include requests for information about accessing services or how to make a complaint.

Definition of complaint

A complaint is an expression of dissatisfaction about a service for which a response or resolution is explicitly or implicitly expected from the MHCC or is legally required (based on Australian Standard AS/NZS 10002:2014). Complaints can be made orally or in writing. To be formally accepted, they need to be made or confirmed in writing.

Why complaints are important

When people feel supported to speak up about their concerns, when they can exercise their right to make a complaint and feel heard and respected, then they are also more likely to feel supported in their recovery and know that their experience matters. People can also benefit from knowing their complaints can create lasting change to Victorian mental health services and prevent other people from having similar experiences.

How people make complaints

People can make complaints to the MHCC via phone, email, fax, letter and face to face, as well as through our online complaint form and through our social media sites. Most contacts with our office are through our 1800 phone number. In 2018–19 we received 8,225 calls through this phone line, a six per cent increase on the 7,790 received in 2017–18. Seventy-three per cent of complaints made to our office in 2018–19 were made by phone.

The most common complaints that people make by phone are about:

- lack of involvement in care and treatment, particularly during an inpatient admission
- rights as a compulsory patient, including the extent to which people are supported to make treatment decisions, concerns about the process for initiating compulsory treatment, or people not being told about their rights and supported to exercise them
- concerns that people are not ready to be discharged from an inpatient unit, or that the discharge has not been adequately planned
- concerns about the safety and wellbeing of consumers
- unclear or confusing information being provided to consumers, families and carers by staff.

Dealing with complaints requires considerable time and skill on the part of our Resolutions team members, who are often responding to people experiencing significant distress. Through talking to people over the phone we can clarify their concerns and what they are seeking from complaining and then contact the service (with the person’s consent) to resolve their concerns as quickly as possible. By engaging the service in responding to the person’s concerns, the person is helped to feel more safe and confident speaking to them directly about any future concerns.

Complaints to the MHCC involving safeguarding issues or quality and safety concerns often require a formal response from the service. In these instances, after addressing any immediate safety issues with the service, we will support the person making the complaint to do so in writing and will then seek a formal written response from the service regarding the issues identified and assess this in accordance with the process outlined on page 13 (see ‘Risk and safeguarding issues’).

Who made complaints to the MHCC?

Consumers raised 72 per cent (1,577 of 2,195) of new enquiries and complaints made in 2018–19 (compared with 1,579 in 2017–18), and family members and carers raised 23 per cent (500 complaints and enquiries, an increase from 440 in 2017–18). The remaining complaints and enquiries were made by advocates, legal representatives, friends and staff from other services, or came to us by referral from other bodies (see Figure 3).

Given that people who contact our office often call during a very distressing time, it is not always appropriate or possible to request and record demographic data. We continue to work on ways to better capture this data and promote the accessibility of our office to priority population groups.

Figure 3
who made enquiries and complaints?
base: new enquiries and complaints raised with the MHCC (n = 2195)

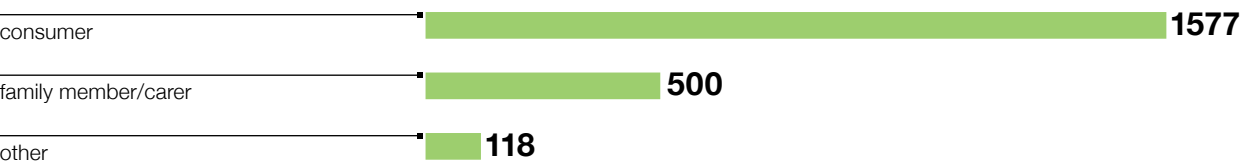
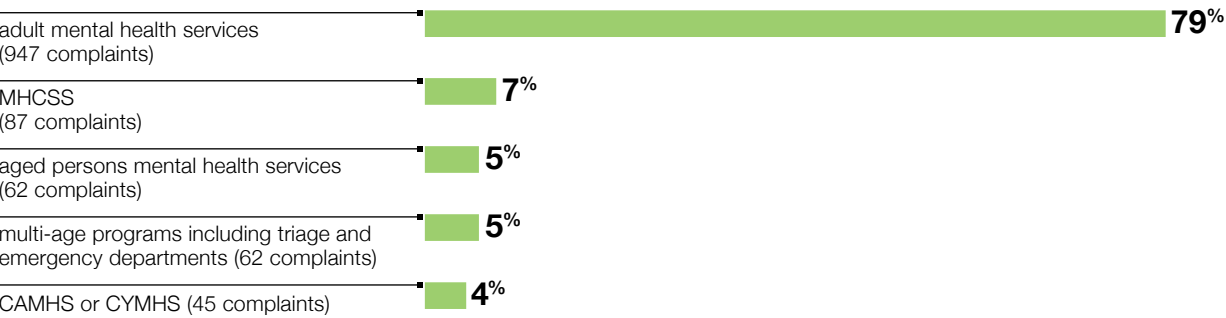


Figure 4

service program breakdown
all in-scope complaints raised with the MHCC where service program and service type were identified (n = 1203 see footnote 1)



When we receive complaints from family members and carers, we discuss the options that are available to resolve their concerns. These include:

- providing information or coaching to assist them to resolve their concerns directly with the mental health service
- asking the consumer’s consent for our office to deal with the complaint
- considering if there are special circumstances that would allow us to accept the complaint without the consumer’s consent in accordance with the Act.

We recognise and respect the important role families and carers play in raising issues on behalf of a consumer. When we accept a complaint from a carer or family member, we first seek consent from the consumer and involve the consumer in resolving the complaint as much as the consumer wishes. Under the Act, the consumer must be kept informed in writing about the complaint as it progresses.

What type of services were complaints about?

Of the 1,508 in-scope complaints made to the MHCC in 2018–19, 1,421 (94 per cent) were about designated mental health services and 87 (six per cent) about mental health community support services (MHCSS). This breakdown is similar to previous years and is likely largely due to the higher numbers of people who access designated mental health services than MHCSS. In addition, as compulsory treatment can only be provided by designated mental health services this is likely to lead to a higher number of complaints about those services.

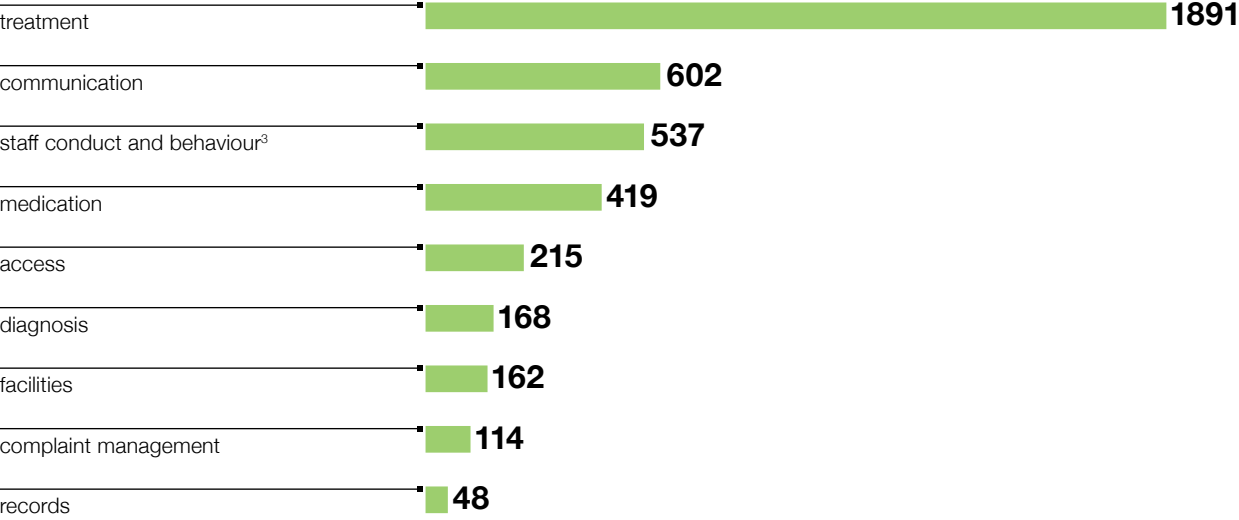
How many complaints were made about different types of mental health services?

- Of the in-scope complaints made to our office in 2018–19 where a service program was identified² (1,203):
- 79 per cent were about adult mental health services, including forensic services
 - 7 per cent were about MHCSS
 - 5 per cent were about aged persons mental health services
 - 5 per cent were about programs that provide services to people of all ages, including triage and emergency departments
 - 4 per cent were about child and youth mental health services (CYMHS) or child and adolescent mental health services (CAMHS) (see Figure 4).

2 It is not possible to identify a program type for all complaints. For example, sometimes this information is not initially provided and we are unable to make further contact with the person to confirm the details of their complaint.

Figure 5

what did people make complaints about in 2018–19?
number of issues identified in in-scope complaints raised with the MHCC



What did people make complaints about?

Complaints raised with our office are often complex, and most involve more than one issue. In this report, issues are described in terms of the number of times they occurred in in-scope complaints about public mental health services received in 2018–19. Issues raised less than 50 times or in less than three per cent of complaints are not reported in detail but are included in the discussion in each section, with the exception of some of the smaller issue categories where examples would not otherwise be provided.

In 2018–19 we revised our issue categories to record people’s experiences in mental health services in more detail and with more accuracy to reflect the requirements and principles of the Act. This means that this analysis of issues is not directly comparable with previous reports. However, from 2018–19 the issues data will more accurately and comprehensively describe people’s experiences in mental health services, which will better inform the MHCC and services.

In 2018–19 treatment was the most common issue identified in new complaints (raised 1,891 times). Consistent with overall trends in previous years, the next most common issue was concerns about communication (raised 602 times), followed by issues about conduct and behaviour (raised 537 times) (see Figure 5).

While the MHCC’s issues categories may have changed, the common concerns raised about treatment, communication and staff behaviour are consistent with previous years. This indicates the need for services to continue to work on ways to support people to make decisions and choices about their treatment and care, and to support staff to treat all consumers, families and carers with courtesy and empathy during what are often extremely difficult times in people’s lives.

3 Includes rudeness

Example complaint

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

Minh’s complaint

Summary

Minh, who was receiving compulsory mental health treatment, contacted the MHCC because he didn’t want to be a compulsory patient, was unhappy with the side effects of medication he was taking, and didn’t feel his views and preferences were being heard.

What Minh told us

Minh told us that he’d experienced unpleasant physical side effects since he began receiving depot injections, including nausea and headaches. He explained to the MHCC that he would prefer another option.

How the mental health principles and the requirements of the Act applied to the complaint

The Mental Health Act protects the rights of people receiving mental health treatment from a public mental health service. Anyone accessing care and treatment should expect the service’s approach to be guided by the principles and requirements in the Act.

The principles most relevant to Minh’s complaint are:

a Provide least restrictive treatment

Persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible, with voluntary assessment and treatment preferred.

c Ensure supported decision making

Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in those decisions and their views and preferences should be respected.

The Act provides that all people receiving mental health treatment, including compulsory patients, must be presumed to be able to give informed consent to treatment (see s 70) and the informed consent of a person with capacity must be sought before treatment is administered. Section 68 of the Act provides that a person has capacity to give informed consent if they can understand, remember, use, weigh and communicate information that is relevant to the decision to be made. This section also sets out principles to help services determine whether a person has capacity to give informed consent to treatment.

Section 69 of the Act sets out the requirements for ensuring a person can give informed consent to treatment, including that the person:

- has capacity to consent to treatment
- has been given adequate information to make the decision, including an explanation of the proposed treatment (including side effects) and information about any beneficial alternative treatments that are reasonably available
- has been given a reasonable opportunity to make the decision
- has given consent freely without undue pressure or coercion
- has not withdrawn consent.

Where a patient with capacity does not consent to treatment, section 71 of the Act enables the authorised psychiatrist to make a treatment decision for the person if there is no less restrictive way for the person to be treated. The consideration of what is less restrictive requires the authorised psychiatrist to consider the patient’s views and preferences about treatment.

What do the principles and requirements of the Act mean for Minh?

The principles and requirements of the Act state that Minh should be presumed to be able to make decisions about his treatment, to be supported to make and participate in decisions about treatment and that his views and preferences about his treatment should be respected.

In this instance, Minh should be presumed to have capacity to make an informed decision about his treatment. His treating team should discuss any other reasonably available and effective medication options with him, including information about risks and benefits of the various options, to see if there is a reasonably available, beneficial alternative treatment that he would agree to. If so, this could be a less restrictive treatment option than depot injections, that the service should consider.

Our involvement

Minh had told us that he had recently made an appeal to the Mental Health Tribunal about his compulsory treatment and that his treatment order had been upheld. As part of our assessment of Minh’s complaint, we checked that Minh had been offered the chance to access a second psychiatric opinion, which he had. Our staff explained to Minh that while the MHCC cannot stop compulsory treatment, we could support him to make sure his views and preferences about treatment were heard by the service. Minh told us that he would be comfortable taking oral medication rather than having a depot injection. Our staff sought Minh’s consent to speak to the service about his concerns, and to give the service a chance to resolve them. The service agreed to speak with Minh about his concerns to see if they could resolve his complaint.

A service representative contacted the MHCC to advise that she had met with Minh to hear his concerns and that she had organised a clinical review with a doctor to discuss changing Minh’s medication. She told us that Minh had asked that he have an advocate present at the meeting, and that she was supporting him to make sure that occurred.

After this conversation, we contacted Minh, who was still experiencing distressing physical side effects from his current medication. Our staff encouraged Minh to take notes of the things he had raised with the MHCC and provided some coaching about how he could communicate his views and preferences about medication to the service at the review.

Outcomes

Minh contacted the MHCC to confirm that, following the review, at which he was supported by an advocate, he was now receiving oral medication rather than a depot. Minh was happy with this outcome, and we closed the complaint accordingly. Our involvement with this complaint reinforced the need for the service to ensure that treatment decisions reflect the principles of supported decision making and least restrictive treatment.

Complaints about treatment

Seventy-one per cent of in-scope complaints to the MHCC raised issues about treatment (1,891 issues in total). Many complaints raised more than one issue about treatment (see Figure 6). Treatment is broken down into several further categories:

- ‘suboptimal treatment’⁴ (raised 846 times): this category includes concerns about:
 - disagreeing with compulsory assessment or treatment
 - whether consumers’ treatment was well planned and responded to their holistic needs including medical or physical health needs
 - advance statements not being considered, and access to a second psychiatric opinion
- responsiveness of staff (raised 583 times): concerns about how staff took the views and preferences of consumers, families, carers and nominated persons into account
- inappropriate discharge or transfer (raised 228 times), including concerns that discharge was unsafe or inadequate (including inadequate communication about discharge) as well as concerns about the information included in discharge plans
- restrictive interventions (raised 88 times), including concerns about whether restrictive interventions were necessary as well as whether legislative requirements for its use were met

Other less frequently raised treatment issues included (in order of frequency) inadequate follow-up including no or inadequate follow-up after discharge, specific adverse outcomes including unexpected complications, physical or psychological injury and self-harm and concerns about incorrect treatment.

The most common specific treatment issues were lack of consideration of the consumer’s views and preferences about treatment, as well as people disagreeing with compulsory assessment or treatment. The prevalence of these issues points to the need for concerted efforts by services to uphold the mental health principles that promote supported decision making and the least restrictive treatment options, and to provide treatment in ways envisaged by the objectives of the Act. These issues are highlighted in the example complaint on page 18.

Figure 6
what treatment issues did people make complaints about?

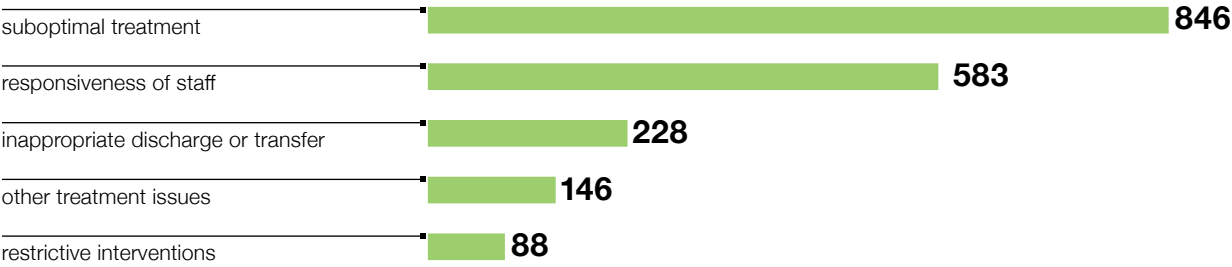
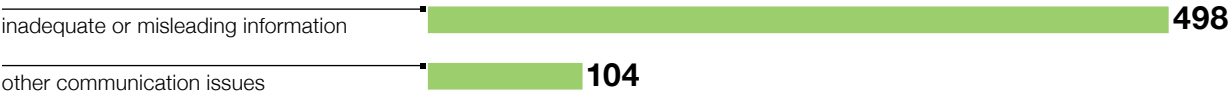


Figure 7
what communication issues did people make complaints about?



4 The category of ‘suboptimal treatment’ is included in the Victorian Health Incident Management System (VHIMS) used by designated mental health services.

need for services to address this fundamental requirement of person-centred care and to consider ways of promoting effective and supportive communication with people and their support people during treatment. This includes ways of ensuring that staff provide consistent and timely information in ways that people can understand and use, taking into account people’s level of distress and capacity to absorb information, and checking their understanding at different points of time. The complaint outlined on page 22 provides an example of a complaint where the consumer and their family/carers were given inadequate information about the plans that were being put in place to provide care and treatment at a time when the consumer was seeking help with suicidal thoughts. In this instance, poor communication was a factor in the consumer leaving the emergency department and experiencing harm.

Complaints about conduct and behaviour

Complaints about conduct and behaviour were raised in 27 per cent of in-scope complaints to the MHCC (578 issues raised in 2018–19). These complaints are mainly about staff conduct, however they also include allegations of sexual or physical assault, or threats, bullying or harassment by another consumer.

These complaints go to the heart of people’s experiences and highlight the harmful impacts when people feel a lack of respect, compassion and empathy in their interactions with staff. These complaints also highlight the need for staff to act in ways to ensure people’s safety, including their physical, sexual, psychological and cultural safety.

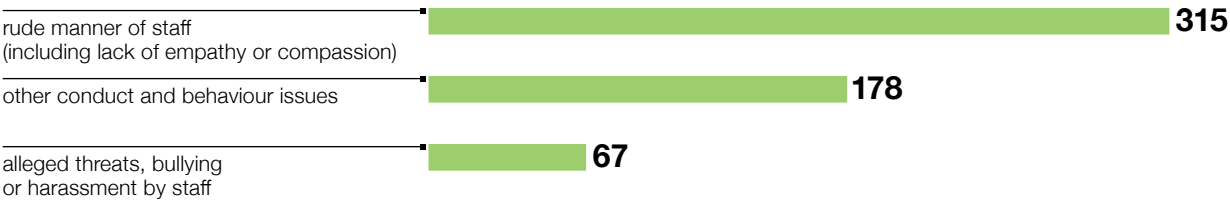
Conduct and behaviour issues are broken down in the following sub categories:

- rude manner of staff (including lack of empathy or compassion) was raised 315 times, overwhelmingly the most common issue in this category. This points to the need for services to recognise the significant impacts for consumers, families and carers where they experience rudeness or a lack of empathy from staff, and to consider how staff can be best supported to engage in ways that consumers, families and carers find respectful and supportive. See the example complaint on page 22 for an example of the way in which a perceived lack of empathy and responsiveness by staff can have a significant negative outcome for a person experiencing distress, and their family.
- other conduct and behaviour issues (raised 78 times); includes a lack of dignity experienced by consumers
- alleged threats, bullying or harassment by staff (raised 67 times): includes alleged threats, bullying, harassment or verbal abuse by clinical or security staff.

There were also a range of less frequent but very concerning complaints about alleged discriminatory behaviour by staff, and complaints about alleged physical assaults and sexual assaults, sexual harassment or sexual activity by either co-consumers or staff, and experiences of threats, bullying or harassment by another consumer. Complaints involving allegations of physical or sexual assault and other safeguarding issues are always escalated for immediate action to ensure the person is currently safe. People are supported to make a formal complaint so that these complaints can be thoroughly assessed and appropriate prevention action taken, as well as action to support the person making the complaint. See page 44 for an example of a complaint involving serious allegations against staff and the actions taken by the MHCC in response to this complaint.

Examples of the types of actions taken by the MHCC to deal with these significant conduct and safety issues are discussed below under ‘What other actions were taken to address risk and safeguarding issues?’ and ‘Investigations’.

Figure 8
what conduct and behaviour issues did people make complaints about?



Example complaint

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

Alex and Nerida’s complaint

Summary

Alex, a young man, drove to a hospital emergency department experiencing suicidal thoughts. He found the response from the staff unsympathetic and unhelpful. His mother and carer, Nerida, also tried to speak to staff at the emergency department but felt that her views weren’t heard.

What Alex and Nerida told us

Alex was experiencing thoughts of self-harm and suicide and drove himself to hospital to seek help. Alex was told by staff that he could either drive himself to another part of the service to be assessed or come inside and ‘wait his turn at the emergency department like everyone else’.

Alex told staff that he had taken medication, that he needed immediate help with his suicidal thoughts and it was unsafe to drive. Alex told us that the staff member told him he seemed ‘fine’ and this felt dismissive of the severity of his distress and lacking in compassion. Alex then called his mother, Nerida, who tried to explain to the staff member that Alex was severely distressed and had a history of attempted suicide. Alex and Nerida told us that they had not been informed that the hospital had been putting plans in place to provide care and treatment to Alex within the emergency department while these discussions were occurring. Believing he would not receive the help he needed, Alex left the hospital and sustained a serious injury in an incident that occurred soon after leaving.

Nerida made a complaint to the hospital about the staff member’s lack of communication about the plans to assist Alex, and the lack of empathy she and Alex had experienced in their interactions with staff. Nerida was concerned that the lack of compassion Alex experienced was directly related to him leaving the emergency department and being seriously injured. Nerida wasn’t happy with the service’s initial response to her complaint and contacted the MHCC.

How the mental health principles applied to the complaint

The Mental Health Act protects the rights of people receiving mental health treatment from a public mental health service. Anyone accessing care and treatment should expect the service’s approach to be guided by the mental health principles in the Act.

The principles most relevant to Alex and Nerida’s complaint are:

C Ensure supported decision making
Persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected.

K Involve carers
Carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible.

I Recognise, respect and support carers
Carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.

What do the principles mean for Alex and Nerida?

Alex had the right to have his concerns that he was suicidal and not safe to wait a long time or drive elsewhere acknowledged, and to be involved in and informed about plans for his treatment.

Nerida, as Alex’s mother and carer, had the right to be listened to and involved in decision making when she advised the staff member about Alex’s history and current need for help.

In practice, these principles mean that both Alex and Nerida were entitled to receive compassionate and responsive care when seeking help and communication with the service.

The complaint about the experiences of Alex and Nerida also raised serious questions about the apparent failure to provide mental health services to Alex in response to his expressed need for help, which can be a basis for making a complaint to the MHCC.

Our involvement

After hearing Nerida’s concerns, we contacted Alex with her consent. Alex consented to Nerida making the complaint on his behalf. We assessed that Alex and Nerida’s complaint raised serious issues about whether the service had adequately upheld the mental health principles to support consumers to make or participate in decisions, and to involve carers in decisions, and to provide an appropriate mental health service response.

We assessed that the consequences of Alex and Nerida’s experiences could have been even more serious and that we needed to ascertain what steps the service had put in place to ensure consumers’ and carers’ views are listened to and respected, and that services communicate clearly with consumers and carers. Following receipt of the service’s written response to these issues, we facilitated a meeting between the service, Alex and Nerida to ensure Alex and Nerida had the opportunity to explain the impact of their experiences, and to seek a further response from the service about these issues.

In the meeting, representatives from the service apologised for not seeking information from Nerida, and for not clearly explaining the plans for Alex’s treatment. They acknowledged the significant impact these experiences had had on Alex and Nerida and outlined several service improvements they were making in response to the complaint. These included:

- training for all staff on being responsive to consumers’ needs, views and preferences, and to hearing carers’ views and addressing their concerns
- additional training for the staff member involved in Alex’s care, including on assessing and responding to consumers’ suicide risk
- planning for the short-term treatment team to move closer to the emergency department to improve ease of access to this team

– creating an extra room in the emergency department for staff to speak with people in a quiet space.

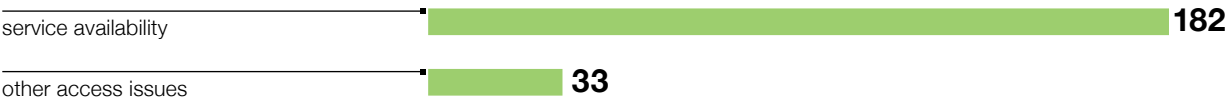
Outcomes

After the meeting, we contacted Alex and Nerida to ask for their perspectives. Nerida told us that hearing an open acknowledgement by the service about where they could improve and understanding the steps they had put in place to improve, had addressed and resolved her concerns. We assessed that the steps the service identified were appropriate to address the concerns raised and closed it on this basis and given that Alex and Nerida were also satisfied with the outcome of the complaint. We also identified the systemic issue of people with suicidal thoughts not receiving appropriate mental health treatment when seeking help at emergency departments, along with the need for compassionate care and responses from staff. These themes from complaints have been highlighted in our submissions and consultations for the Royal Commission into Mental Health and the mental health inquiry by the Productivity Commission.

Figure 9
what medication issues did people make complaints about?



Figure 10
what access issues did people make complaints about?



Complaints about medication

Twenty-three per cent of in-scope complaints to the MHCC raised at least one medication issue (419 issues in total). The most common medication issue was complaints about medication concerns (including errors), which was raised 365 times (see Figure 9). Most of these complaints were about unnecessary medication, side effects of medication, dissatisfaction with changes to prescribed medication or a preference for oral medication rather than depot medication. An example of this kind of complaint, where a person experienced distressing side effects as a result of their medication and had a preference for oral rather than depot medication, is on page 18.

The remaining 55 medication issues were about other issues such as refusal to prescribe or dispense particular medications.

Complaints about access to services

Concerns about access to services were raised in 13 per cent of in-scope complaints to the MHCC (215 separate issues (see Figure 10)). This included complaints about:

- service availability (raised 182 times): most of these complaints were about lack of or insufficient access to services, delays in assessment or treatment, refusal to assess, admit or treat a person, or people being unable to access a service because of their coexisting alcohol and drug needs
- other access issues (33 issues) including inappropriate fees or billing, other access issues, language or physical access needs not being accommodated and administration issues.

The example on page 22 shows the impact that delay in accessing a service, including apprehension of delay in being able to access a service through an emergency department, can have for consumers, families and carers.

Complaints about diagnosis

Concerns about diagnosis were raised in 10 per cent of in-scope complaints to the MHCC (168 issues (see Figure 11)). This included complaints about:

- incorrect diagnosis (raised 99 times), including concerns about receiving an incorrect diagnosis or inadequate explanation of a diagnosis
- inadequate or inappropriate assessment (raised 59 times), including where a person believed the assessment process was inadequate or disagreed with the outcome of the assessment
- other diagnosis issues including inadequate or inappropriate referral (10 issues).

Figure 11
what diagnosis issues did people make complaints about?

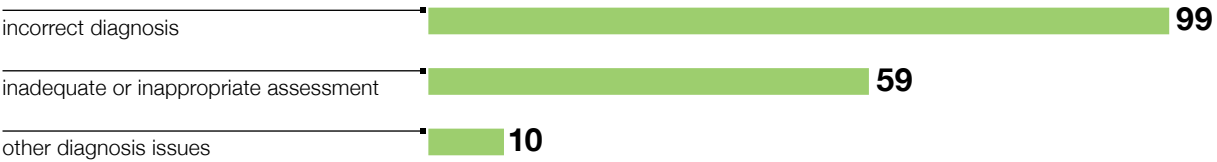


Figure 12
what facilities issues did people make complaints about?



Complaints about facilities

Concerns about the adequacy of facilities were raised in nine per cent of in-scope complaints (162 issues (see Figure 12)). This included complaints about:

- security (raised 71 times), including lost or stolen property, people experiencing a lack of privacy, lack of gender safety or a general feeling of lack of safety, or the presence of illicit drugs in the facility
- accommodation (raised 47 times), including concerns about food quality, issues with noise, lighting or the temperature of the facility or problems with bedding or furniture
- other facilities issues (44), including cleanliness and lack of adequate equipment and resources.

People have a right to be and feel safe when receiving mental health treatment, and the built environment can impact on people’s safety. It is acknowledged that some services are managing outdated or inadequate facilities which do not support safety. However, there are often actions that services can take to mitigate the challenges associated with outdated infrastructure. An example of a complaint where a woman felt unsafe in an acute inpatient unit, partially because of how the existing infrastructure was used, is included at page 48.

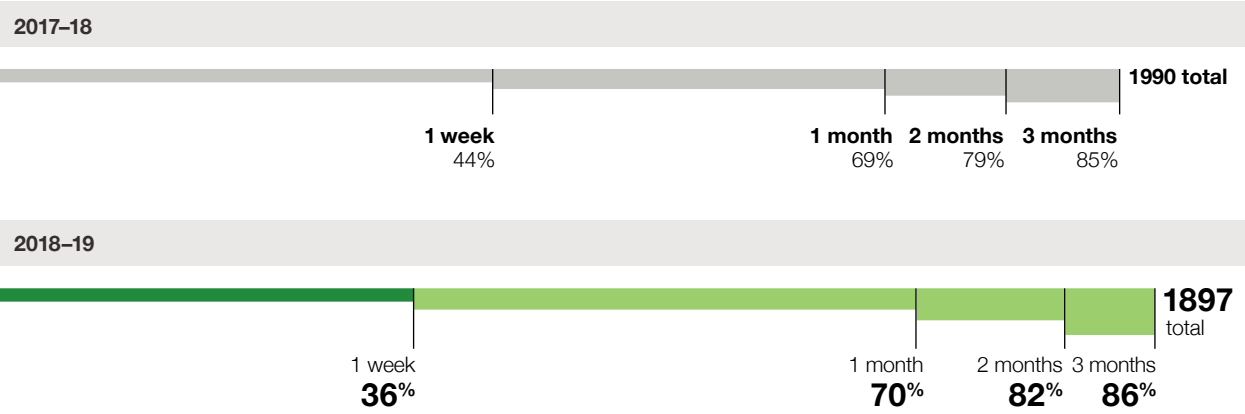
Complaints about how a complaint was managed

Issues about how a complaint was managed by a mental health service were raised in seven per cent of all in-scope complaints (114 issues in 2018–19). This includes complaints about:

- inadequate or no response (raised 78 times), including where a person received an inadequate or no response to a complaint made directly to a service or where they were dissatisfied with the timeliness, process or outcome of a complaint
- other complaint management issues (36), including fear of or a direct experience of retaliation as a result of making a complaint, and finding the complaint process difficult to navigate.

Some other complaint issues, including complaints about record management, were raised fewer than 50 times and are not reported on in this report.

Figure 13
how long did it take to finalise complaints?
base: all complaints closed by the MHCC (n = 1897)



Closure

Time taken to close complaints

In 2018–19 we dealt with 2,276 complaints (excluding enquiries), made up of 1,976 received during the year (1,508 of which were in scope) and 300 carried forward from 2017–18. In total, 1,897 complaints were closed during 2018–19, with 1,437 of these being in-scope complaints.

Thirty-six per cent of all complaints were closed within one week, a further 34 per cent were closed within one month, 12 per cent within two months and four per cent within three months. The remaining 14 per cent took more than three months to close (see Figure 13).

This is broadly consistent with previous years, with a larger percentage of complaints taking between one week and one month to close and fewer complaints taking more than three months to close. The high number of oral complaints made to our office can generally be addressed promptly through early resolution including staff facilitating direct resolution by services. Written complaints are often more complex, and this is shown in the complaints requiring more than three months to close. However, the number of complaints taking more than three months to close has decreased from 303 in 2017–18 to 266, which reflects significant efforts made by the office to finalise older complaints and improve the timeliness of responses to complaints.

Most complaints open at 30 June 2019 (369) were written complaints at various stages of assessment, resolution or investigation. This continues a trend of an increasing cumulative total of complex complaints, with 300 complaints open at 30 June 2018.

To accurately show our work in resolving complaints about public mental health services, the MHCC excludes all matters assessed as ‘resolution not applicable/possible’ when reporting on complaint outcomes. These are complaints where, for example:

- we were unable to progress the complaint because we could not contact the person who made the complaint
- the consumer at the centre of the complaint did not consent to the complaint proceeding, and we assessed that there were no special circumstances for accepting the complaint without consent
- we were unable to take further steps without the complaint being confirmed in writing and accepted as a formal complaint
- the complaint was more appropriately dealt with by another body (for example, the Mental Health Tribunal or Australian Health Practitioner Regulation Agency).

We provide information and assistance to address the concerns raised in *all* matters that come to our office, in line with our ‘no wrong door’ policy. If the complaint is out of scope, we provide the person with advice and information and follow-up with contacts and referrals wherever possible.

Complaints about public mental health services

Of the 1,897 complaints closed in 2018–19, 1,437 were in scope. The remainder of the closed complaints (460) were matters that the MHCC was unable to deal with and are referred to as out of scope (see Figure 14).⁵ The main reason that complaints were out of scope was because they were not about a public mental health service (422, or 92 per cent of out-of-scope complaints). As noted previously, the MHCC received a higher number of complaints that were not about a public mental health service than in previous years, which appears to be attributed to the media coverage of the Royal Commission into Victoria’s Mental Health System and its broader focus on mental health services.

Of the 1,437 closed in-scope complaints, 427 complaints were in scope for resolution and a further 486 were facilitated to the service following initial discussions and coaching with the service and the person about what may help to resolve the complaint. In these instances, our practice is to always invite the person to contact the MHCC again if the service is unable to resolve their concerns. The remainder of the in-scope complaints (524) were assessed as resolution not applicable/possible.

How many complaints were resolved?

Of the 427 closed complaints that were in scope for detailed assessment and resolution, 349 (82 per cent) had positive outcomes and actions for consumers, families and carers. Of the 427 closed complaints that were in scope for resolution only, 78 (18 per cent) were not resolved. The reasons why it is not possible to achieve positive outcomes for all complaints are discussed below. This is slightly higher than the percentage of complaints closed through detailed MHCC assessment and resolution processes that were not resolved in 2017–18 (16 per cent).

In the 427 complaints closed through detailed MHCC assessment and resolution processes:

- 35 per cent (151) were fully or substantially resolved
- 47 per cent (198) were partially resolved
- 18 per cent (78) were not resolved (see Figure 15).

Where concerns were fully or partially resolved, our assessment and resolution processes can include reviewing records, policies and written responses and reports, and facilitating meetings between services, consumers and carers.

The 427 complaints closed through our detailed assessment and resolution processes represent a 20 per cent increase on the 357 complaints closed in this way in 2017–18. As at 30 June 2019, 369 complaints were still open and being dealt with in various stages of assessment and resolution. Most of these cases require longer term action, follow-up with services and in some cases investigation or consideration of undertakings to ensure the quality and safety issues have been addressed.

Figure 14
in- and out-of-scope complaints
base: complaints closed (n = 1897)

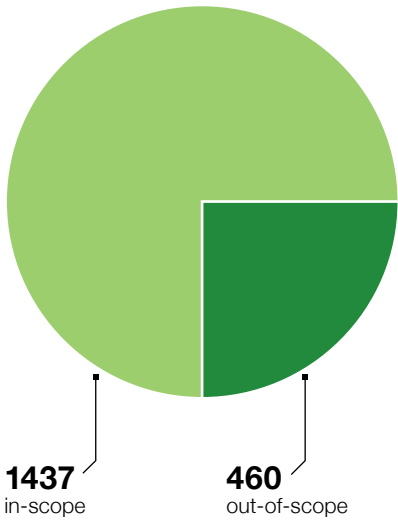
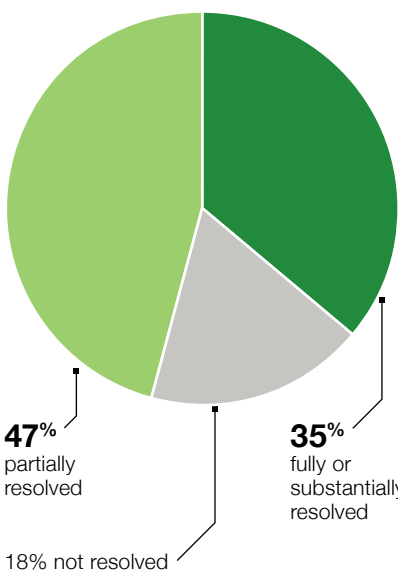


Figure 15
how many complaints were resolved?
base: in-scope complaints closed through detailed MHCC assessment and resolution processes (n = 427)



⁵ Out-of-scope complaints include those that were not about a public mental health service or mental health issue or occurred before 1 July 2013 (the MHCC was established on 1 July 2014 and is unable to deal with complaints that relate to events that occurred more than 12 months before this date). The MHCC received 460 complaints that were out of scope in 2018–19; however, 369 of these were still open at 30 July 2019 to enable follow-up assistance to be provided and are therefore not included in the closure data.

What does resolution mean?

Fully or substantially resolved

Complaints where issues were either fully or substantially resolved or an agreement was reached on the proposed actions to address the issues raised. Overall these complaints achieve a positive outcome in terms of the person’s concerns.

Partially resolved

Complaints where one or more of multiple issues raised were resolved, or partially resolved. Partially resolved complaints include complaints where the service committed to improvement actions that we assessed as appropriate in the circumstances but where the person was not fully satisfied with the outcome.

Not resolved

We recognise that it is not always possible to resolve complaints made to our office. In some complaints there are barriers to achieving a positive outcome, such as services not being able to reach agreement on the outcomes sought by the person. Where appropriate, we provide advice and recommendations to the service or to the individual about other possible courses of action, including referring them to Victoria Legal Aid or community legal centres for legal advice.

The Four As of complaints resolution

Acknowledgement

People want their concerns to be heard and acknowledged and the impact of their experience to be recognised and understood. Acknowledgement of their rights and what should have occurred in a situation can also be important.

Answers

People are usually looking for an explanation as to why something happened or did not happen, or why a certain decision was made. For answers to be meaningful, they need to be provided in a way that can be readily understood by the person, and that encourages the person to ask further questions if needed.

Action

People will generally be seeking action to address their individual issue or a change to be made to improve their experience and treatment. Many people also make a complaint because they do not want a recurrence of the issue for themselves or for others and because they want services to take actions to achieve this.

Apology

A meaningful apology usually involves acknowledgement, answers and actions by a service and, where appropriate, can assist in a person’s recovery and help to restore their confidence in the service.

What happened because people made complaints?

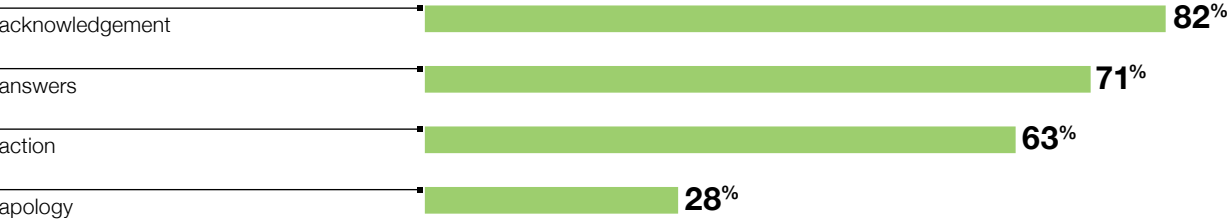
The outcomes of the 427 in-scope complaints closed by MHCC where resolution actions were taken are categorised by the four As of complaints resolution. Note: most of the complaints had more than one resolution action:

- 350 or 82 per cent showed the service had acknowledged the person’s experience
- 304 or 71 per cent resulted in explanations or answers about the complaint issues
- 271 or 63 per cent showed that action had been taken because of the complaint
- 120 or 28 per cent resulted in an apology from the service (see Figure 16).

Figure 16

what happened when people made a complaint?

base: in-scope complaints closed through detailed MHCC assessment and resolution processes (n = 427)



Apologies and acknowledgements are critical in building or restoring a person’s relationship with their treating team and the service and can provide a foundation to work through other issues that may be affecting the person’s treatment and recovery. We continue to work with services on strengthening these important ways of resolving complaints and supporting people’s recovery.

Actions were a common outcome of complaints to our office. The most common actions taken by services to address individual concerns were:

- addressing communication issues and resolving misunderstandings between the person and service
- services changing the way support or a service was provided to the person
- services arranging a meeting with the consumer, their family or carer to discuss and attempt to resolve issues
- the service agreeing to respond to the complaint directly
- immediate safety or risk issues being addressed by the service.

Services have continued to work collaboratively with the MHCC to resolve complaints in constructive and positive ways. In 2018–19, 88 service improvements were recorded. Improvements occurred in various circumstances including:

- where a service proactively initiated an improvement after receiving the complaint
- because of discussions between the service and the MHCC through the resolution process
- in response to formal MHCC recommendations.

Learn more in the ‘Promoting service and system improvement’ section on pages 39–50.

What other actions were taken to address risk and safeguarding issues?

While all complaints to the MHCC are assessed for risk and safeguarding issues, the nature and gravity of the issues in some complaints warrant allocation to our specialist advice and investigation team to determine the most appropriate action.

In 2018–19, 30 complaints were subject to the following detailed processes to address specific risk and safeguarding issues including alleged breaches of the Act, questions about the lawfulness of service actions, risks of abuse or neglect of vulnerable consumers, and significant adverse events and harms experienced by consumers:

- formal investigations (1 completed, 3 being completed at 30 June 2019)
- assessment and referral to investigation following review of clinical records (3)
- review and follow-up of recommendations from sexual safety investigations (4)
- referral to conciliation for potential settlements (3 current, 1 closed)
- receipt and monitoring undertakings from services (3 completed, 1 current)
- review of complaints for potential undertakings and/or conciliation (6)
- examination of clinical records for safeguarding issues and potential breaches to determine appropriate actions (7)
- assessment conference to address need for complex care planning and escalation (1)
- referral to AHPRA to investigate alleged staff misconduct (5)
- referral to HCC for alleged breach of Health Records Act (1)
- complaint about alleged misconduct of NDIS provider jointly assessed with Disability Services Commissioner and formal referrals for regulatory action to NDIA and DHHS (1).⁶

All these complaints raise complex issues which require detailed examination and consideration of the most effective actions to achieve a resolution for the person and to address the risk and safeguarding issues identified in the complaint. While not all complaints were referred to formal investigation, most of these complaints included detailed review of the clinical records and processes which elicited detailed accounts from the consumer of their experience or witness statements. An example of the range of actions that the MHCC has taken to address significant safeguarding issues in complaints is provided at page 44. The issues identified in four of these complaints also informed formal recommendations to the Secretary of DHHS which are outlined on page 43.

The MHCC’s approach to investigations and the types of complaints that are referred to these processes are discussed below. The additional budget allocated to the MHCC in the Victorian 2019–20 Budget will enable more complaints to be referred to investigation in the coming year.

6 Some of these complaints included more than one action, such as an undertaking plus a referral to conciliation

Investigations

Once a complaint has been accepted, the MHCC may conduct an investigation. When deciding whether to investigate, the Commissioner will consider:

- the nature and seriousness of the issues raised
- whether there are issues of quality, safety or rights that require examination and determination of what happened, particularly where there are disputed accounts
- the MHCC’s role in safeguarding and upholding people’s rights
- whether there are other effective complaint resolution options or actions available such as an undertaking by the service or conciliation.

When an investigation begins, the consumer, the person making the complaint and the mental health service provider will be notified in writing.

A central part of the investigation process is providing the opportunity for the consumer and the person who made the complaint (if not the consumer) to provide a detailed account of their experience and concerns through interviews and by providing any additional supporting documents. The MHCC will also request clinical records and documents from the mental health service provider, interview staff and inspect the facilities if required to make findings on the issues under investigation.

The MHCC will prepare a de-identified investigation report documenting the Commissioner’s findings and recommendations for service improvement. Copies of the investigation report will be provided to the mental health service provider, the consumer and the person who made the complaint (if not the consumer), if this will not unreasonably breach the privacy of the consumer.

In accordance with the Mental Health Act, the mental health service provider must respond to the report within 30 business days of receiving it. The response must detail the actions it has taken or will take to resolve the complaint. In practice, the MHCC seeks a response to our recommendations and a detailed action plan for implementation.

The MHCC monitors and reviews implementation of our recommendations. The MHCC will also work with the consumer, the person making the complaint and the mental health service provider on any further actions that can be taken to resolve the complaint.

Investigations begun and underway in 2018–19

In 2018–19 we formally began two investigations and started the processes to conduct another two investigations. We also continued work on an investigation that began at the end of 2017–18.

Each of these investigations raise a number of serious issues relating to the lawfulness of action taken by services and staff and the rights of people subject to compulsory treatment under the Act. For example, we are investigating:

- alleged assault and verbal and physical abuse of a consumer by mental health service staff in an aged acute mental health unit
- the use of physical and mechanical restraint of a consumer, including whether there was compliance with the requirements of the Act for the use, authorisation and review of restraint
- the circumstances in which electroconvulsive treatment was administered to a consumer who also required medical treatment in an intensive care unit.

The MHCC will continue work on these investigations and will report on outcomes in the 2019–20 annual report.

Key issues identified in an investigation concluded in 2018–19

In 2018–19 we concluded an investigation regarding a consumer’s experience leading up to being placed on an inpatient assessment order and detained at an inpatient unit overnight.

One of the key findings of the investigation was that the mental health service did not adequately consider the Act’s mental health principles in providing care and treatment to the consumer, and in particular the requirements to: provide assessment and treatment in the least restrictive way possible; consider her views and preferences; and respect her autonomy. For example, the investigation found that staff did not seek collateral information from the consumer’s general practitioner or private psychiatrist and did not explore alternatives to an inpatient admission.

A further key finding was that there was complacency by some staff about the impact of detaining a person, with this complacency being inconsistent with human rights and the requirement to provide assessment and treatment in the least restrictive way.

The MHCC made several recommendations to the service, including about the service’s policies and procedures, the training program for medical and nursing staff, and to audit the timeliness of review by a psychiatrist of people on an assessment order for a three-month period.

The service is required to provide its formal response to the MHCC’s investigation report in 2019–20.

This investigation also highlighted a systemic issue about the adequacy of the training provided to staff of designated mental health services who can make assessment orders under the Act. The Commissioner subsequently made a recommendation to the Secretary to DHHS and the Chief Psychiatrist to consider a statewide approach to developing training resources and a training program for staff authorised to make assessment orders.

Investigations concluded in 2017–18

The MHCC engaged in follow-up work in relation to the four sexual safety investigations concluded and reported on in 2017–18.

In summary, the MHCC made several recommendations for service improvements relating to sexual safety, which were accepted by the mental health services involved. We sought and received detailed action plans regarding how the mental health services intended to implement our recommendations and to effect cultural and practice change.

In 2018–19 we held meetings with the relevant mental health services to follow up on the status of their action plans and to ensure there had been effective implementation of our recommendations. We were satisfied with the progress reports we received from the four mental health services involved and are continuing to work with one of these mental health services in respect of a limited number of outstanding issues. Overall, the MHCC has been encouraged by the changes made by these services and the actions being taken to address the specific sexual safety issues and risks identified in the investigations.

The MHCC has also continued to work with the consumers, people making complaints and mental health services involved in these sexual safety investigations to identify and action complaint resolution options that address individual needs and acknowledge consumer experiences.



Local complaints reporting

Our role

Under the *Mental Health Act 2014* (the Act), all public mental health services are required to provide a twice-yearly complaints report to the Mental Health Complaints Commissioner (MHCC). These services include designated mental health services and mental health community support services (MHCSS), including services that provided mental health support services under the National Disability Insurance Scheme (NDIS) up until the transition to the full NDIS scheme on 1 July 2019. The reports must specify the number of complaints received by the service and the outcomes of these complaints.

Our approach

We collate and analyse the complaints data received from mental health services 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 data informs our planning for strategic projects, as well as our recommendations to services and the Department of Health and Human Services to inform service improvements. We also use the data to gain insights into the concerns and experiences of consumers, families and carers (for example, to inform our input into the work of other bodies through consultations and formal submissions) and the current status of complaints processes and reporting systems across the sector.

As in 2017–18, we are reporting on a financial year rather than a calendar year basis to better align with other reporting undertaken by services. In 2019–20 we will distribute individual service provider reports about complaints to services using an updated report format that makes them accessible to a broader audience within services, to assist in identifying quality and safety issues and informing service improvements.

These individual service provider reports show comparative data over three years from 2015–16 to 2017–18. They include comparisons between MHCC complaint data and sector-wide complaint data reported by services as well as comparisons at an individual service level. The reports aim to enable services to identify key areas for attention to inform improvements to both their approaches to complaints and the experiences of people accessing their services.

We will also make available a report comparing statewide trends in MHCC and local complaints. We will continue to meet with mental health services about themes from these reports in the coming year, as well as explore ways in which this data can inform the broader work on quality and safety performance indicators by the Victorian Agency of Health Information (VAHI) and Safer Care Victoria.

Observations about the data

Overall, numbers of complaints reported by services were similar in 2018–19 compared to 2017–18. As in previous reporting periods we continued to observe significant issues in relation to data collection. Considerable work was required by the MHCC to produce a consistent, combined data set that would enable meaningful data analysis.

These issues included inconsistency in the data provided and issues captured and a lack of outcome data reported. We will continue to engage with services to understand the extent to which these data issues are due to reporting and recording issues with current data collection systems and the extent to which practice can change within the current systems to provide more complete data.

Contributions to a future complaints reporting platform

As in previous years many of the challenges in local complaints reporting were associated with issues in the reporting fields and functionality of the Victorian Health Incident Management System (VHIMS), the platform used by most designated mental health services for recording incidents and complaints.

We continue to collaborate with the Victorian Agency for Health Information (VAHI) and the department with the aim of achieving a system that supports services to provide reliable and complete complaints data and the implementation of key recommendations of *Targeting zero: the report of the review of hospital safety and quality assurance in Victoria*.

A note about the data in this section

Caution should be used when interpreting the data from complaints reported by services, as it may not be representative of all complaints dealt with over the reporting period. While quality assurance checks were undertaken, it is likely that different approaches to data collection and reporting have affected the data.

The total number of complaints reported in this section reflects the complaints that were made directly to services only (referred to as in-scope reported complaints). We endeavoured to remove all complaints that were made directly to the MHCC without first being made to the service, to avoid counting complaints twice. However, due to differences in data entry practices at services, it is possible that a small number of complaints reported by services were not clearly identified as complaints that were made through notification from the MHCC.

We note that caution should be used in interpreting differences in the number of complaints reported by different types of services. Higher numbers of complaints may represent effective complaints reporting processes and/or a positive complaints culture. Conversely, it may also demonstrate high numbers of issues experienced by people who use the service. Alternatively, low numbers of complaints may indicate a range of factors, including issues with the recording of complaints or the service's approach to complaints, or a high level of satisfaction with the service.

Overview of complaints reported by services

This overview provides a comparative analysis of data from complaints made to services and to the MHCC for the period 1 July 2018 to 30 June 2019. It compares numbers, service types, issues and sources of complaints.

Given the short timeframe between receiving local complaints data and finalising this report, analysis of complaints outcomes will be included in the statewide report on complaints trends to be published in 2019–20. We note that reporting on complaints outcomes has historically been low (between 20 and 26 per cent of all reported complaints). We will continue to seek to address this with services, as they are required under the Act to include this information in their complaints reports to the MHCC.

This year we achieved a 100 per cent compliance rate, with 64⁷ of the 64 services that provide public mental health services in Victoria submitting full complaints data for 2018–19 to the MHCC. This is consistent with the 98 per cent compliance rate achieved in 2017–18 and the 100 per cent compliance rate achieved in 2016. We appreciate the efforts by services to submit data in a short timeframe to enable financial year reporting.

We received a total of 1,854 in-scope reported complaints over the period 1 July 2018 – 30 June 2019,⁸ a nine per cent increase on the total number of complaints reported by services in 2017–18 (1,702). The MHCC hopes to see a continued increase in the recognition and reporting of complaints directly to services, as this provides a stronger base of information that can be analysed and used to identify opportunities for improvement. We will work with services to develop strategies to see an increase in the numbers and proportions of complaints raised with and resolved by mental health services.

Data for the 2018–19 reporting period was received from 21 designated mental health services, 20 MHCSS and 23 services providing mental health support services under the NDIS. Forty-four services recorded at least one complaint, while 20 services, including 17 services providing mental health support services under the NDIS, indicated that no complaints were recorded over the reporting period. Over the coming year we will seek to engage with services that have consistently reported very low or no complaints to identify the reasons for these trends and whether they would benefit from assistance in improving their approaches to recognising, responding to, recording and reporting complaints. From 1 July 2019, NDIS services are within the jurisdiction of the NDIS Quality and Safeguards Commission, and complaints about these services will no longer be reported to the MHCC.

7 Sixty-three organisations (95 per cent) submitted complaint data in time to be included in the analysis in this report.
8 This total includes 131 complaints from one organisation which submitted their report after the complaint data analysis had been completed.

Complaints reported by services compared to complaints made to the MHCC

A total of 1,854 in-scope complaints were raised directly with mental health services during 2018–19 and reported to the MHCC ('reported in-scope complaints'), which was slightly higher than the 1,508 in-scope complaints⁹ made to the MHCC ('MHCC complaints') during this period. While this is higher than 2017–18, the number of complaints reported by services continues to be lower than would reasonably be expected from the total number of consumers accessing services from designated mental health services, which in 2018–19 was approximately 75,000 consumers.¹⁰

We would expect to see this trend continue as complaint reporting systems improve and as people feel increasingly able, supported and confident to raise complaints directly with services. This will rely on complaints being proactively recognised, responded to and reported by services.

Complaints by type of mental health service provider

The majority of reported complaints were in relation to services provided by designated mental health services, with a smaller number of complaints made about MHCSS and NDIS. A total of 1,597 reported complaints (86 per cent) were from designated mental health services, 238 (13 per cent) were from MHCSS and 19 (one per cent) were from NDIS providers. These proportions are inconsistent with the differences in numbers of registered consumers receiving services from designated mental health services compared to MHCSS in 2018–19, with a greater proportion of complaints received from consumers receiving services from MHCSS.

Complaints reported by MHCSS increased by one per cent from 226 in 2017–18 to 238 in 2018–19 (or 13 per cent of all in-scope complaints reported to the MHCC). Nineteen complaints (one per cent of reported in-scope complaints) related to NDIS providers. As noted above, complaints about NDIS will not be reported to the MHCC from 2019–20.

In contrast, of the in-scope complaints raised directly with the MHCC, most were about designated mental health services (94 per cent), with far fewer about MHCSS (six per cent), which is consistent with previous years. Trends in the number of complaints made to the MHCC and directly to services may indicate that MHCSS as a whole have stronger systems and cultures for reporting complaints compared to designated mental health services.

Complaints per 1,000 consumers

Comparing the number of complaints made to the number of consumers receiving services gives an indication of the extent to which people are inclined to raise complaints with different services. It also facilitates comparisons between services and across time.

According to indicative data provided to the MHCC by the Victorian Agency for Health Information (VAHI), there were 74,731 consumers of designated mental health services 2018–19.¹¹ The total numbers of consumers accessing mental health community support services could not be validated and provided at the time of writing this report. Using this indicative data, there was an average of 21 complaints per 1,000 consumers of designated mental health services, slightly higher than the average of 19 complaints raised directly with the MHCC. This reflects a slight increase on 2017–18 (average of 20 complaints per 1,000 consumers of designated mental health services compared to an average of 22 complaints raised directly with the MHCC), and is a positive sign that people are feeling more able and supported to raise their concerns directly with the service.

Our meetings with services about their complaints data include discussion about the numbers of complaints per 1,000 consumers compared to similar services and sector averages, and ways of interpreting the data and apparent trends. We will continue to monitor these trends and seek to understand the reasons for the differences in the average numbers of complaints per consumers of designated mental health services compared to MHCSS.

9 Out-of-scope complaints made to the MHCC have been excluded to enable direct comparison with complaints made directly to services. The MHCC received 1,976 complaints in total in 2018–19, of which 460 were out of scope. The main reason that complaints were out of scope was that they were not about a Victorian public mental health service. It appears that the Royal Commission into Victoria's Mental Health System prompted more people to make a complaint about their experiences with mental health services, including private mental health services or primary mental health services which are not within the MHCC's scope.
10 Data provided by the Victorian Agency for Health Information on registered consumers of designated mental health services.
11 These consumer numbers provided by VAHI should be treated as indicative numbers for 2018–19 as this data was still subject to further checking and validation at the time of writing this report.

Issues raised in complaints

Complaints reported by services commonly involve more than one issue. Issues are described in terms of how often they occurred in in-scope reported complaints. In light of many complaints having more than one issue, frequency percentages do not equal 100 per cent.

The four most common issues raised in reported complaints related to treatment (raised in 46 per cent of complaints), conduct and behaviour of staff or co-consumers (26 per cent), communication (23 per cent), followed by concerns about facilities (18 per cent). As noted in ‘Safeguarding rights and resolving complaints’ (pages 12–31), the MHCC reviewed and updated issues categories in 2018–19, to more accurately capture and report on people’s experiences. For this reason, issues are not compared directly with 2017–18 data. However, themes are described below.

- The most common issues raised about treatment related to ‘suboptimal treatment’¹² including disagreement with treatment orders, concerns that consumers’ physical health needs were not met, leave concerns and inadequate treatment options or planning. Complaints were also made about lack of care and attention by staff and failure to take into consideration the views and preferences of consumers, as well as poor discharge practices.
- Complaints about conduct and behaviour were most commonly about perceived rudeness by staff, in particular a lack of respect or courtesy.

- Issues reported about communication were most commonly about the provision of inadequate, incomplete or misleading information, or inadequate communication with families and/or carers.
- Complaints about facilities were most commonly about lost, stolen or damaged property or lack of satisfaction with accommodation.

In contrast, 71 per cent of complaints made to the MHCC included concerns about treatment issues, with communication issues the next most common area of concern (raised in 32 per cent of complaints), followed by concerns about staff behaviour or conduct (27 per cent) and medication (23 per cent). While treatment issues were the most frequently raised issues in complaints to both the MHCC and services, the broad gap between complaints to the MHCC and made directly to services that include concerns about treatment is concerning, as it is expected that people would be encouraged and supported to raise any concerns about their treatment as part of their discussions with their treating team. It is not clear whether these concerns are not being recognised as complaints by services or whether people are not feeling confident to raise these types of concerns directly with services. There were also fewer complaints reported by services about sexual safety violations by consumers than complaints to the MHCC which raises further questions which we will follow up with services. These questions continue to inform our education and engagement work with services, and our role in promoting service and systemic improvements.

It is worth noting that there are some differences in the main issues reported by designated mental health services and MHCSS, reflecting the different nature of the services provided. For designated mental health services, the most significant issues were treatment (47 per cent of all complaints), conduct and behaviour (26 per cent), facilities (20 per cent) and communication (20 per cent). For MHCSS the most significant issue reported was communication (43 per cent), followed by treatment (37 per cent), conduct and behaviour (29 per cent) and access (15 per cent).

We continue to observe consistent themes of treatment, communication, and conduct and behaviour in reported complaints. This indicates the need for services to consider ways in which the principles of the Act, particularly how people are supported to make decisions about their assessment, treatment and recovery, are embedded into all aspects of treatment and care.

12 The category of ‘suboptimal treatment’ is included in the Victorian Health Incident Management System (VHIMS) used by designated mental health services.

Service program types

Where the service program type was able to be identified, complaints reported by services were most commonly about adult mental health services including forensic mental health services (69 per cent), similar to the 70 per cent of reported complaints about these services in 2017–18 but lower than the 79 per cent of complaints to the MHCC that were about adult mental health services in 2018–19.

Seven per cent of complaints were about child and youth mental health services (CYMHS) or child and adolescent mental health services (CAMHS), similar to the eight per cent of all reported complaints in 2017–18.

Complaints reported about aged persons mental health services accounted for five per cent of complaints, the same as in 2017–18.

Complaints about programs that provide services to people of all ages, including triage and emergency departments, accounted for six per cent of complaints.

As noted above, complaints reported by MHCSS accounted for 13 per cent of complaints in 2018–19, the same as 2017–18.

In 2018–19, reported complaints were predominantly about inpatient services (55 per cent), with 34 per cent about community-based services (including MHCSS and NDIS), seven per cent about other services (including mental health services provided in emergency departments), and three per cent about residential services (including prevention and recovery care services and community care units). This is similar to 2017–18, when 56 per cent of complaints were about inpatient services and 33 per cent of complaints were about community services.

People who made complaints

The proportion of complaints made by consumers continues to be higher for complaints to the MHCC compared to complaints reported by services. Consumers made 65 per cent of reported complaints compared to 72 per cent of MHCC complaints. The proportion of reported complaints made by consumers also decreased from the 69 per cent of reported complaints in 2017–18. Family members or carers made 27 per cent of reported complaints compared to 23 per cent of MHCC complaints, which was consistent with 2017–18. Four per cent of complaints were made by friends, advocates or legal representatives, or other service providers, while for an additional four per cent of complaints the source of the complaint was unknown.

Our priorities

Local complaints data is an essential source of information for our oversight role of identifying quality and safety issues in complaints and making recommendations for service improvement. It enables us to work with services to identify areas requiring attention and improvement. We will continue to work with mental health services, the department and VAHI to address the critical need to improve complaints reporting systems and processes in order to maximise the value of the information gained. Our aim is for this data to be used alongside the data currently provided in the quality and safety reports produced by VAHI¹³ to enable clearer identification of issues and areas requiring safeguarding and service improvement actions.

13 VAHI produces the *Inspire* reports which include detailed information on a selection of quality and safety measures to inform improvements in safety, quality and outcomes in services. See www.bettersafecare.vic.gov.au/reports-and-publications/VAHI_Reports



Promoting service and system improvement

How do we monitor and review services' responses to our recommendations?

When we make recommendations under the Act, services are expected to commit to the actions necessary to achieve the recommended change. We assess the service's response and request further information or provide further advice if necessary. We also review our records of service improvement actions and recommendations when meeting with services about complaints themes, and when assessing individual complaints where recurring themes are identified.

Figure 17
service improvements

167

Actions to improve services including:

77

recommendations to mental health service providers, the Chief Psychiatrist or Department of Health and Human Services

88

service improvements:
37 training/feedback to staff
26 changes to service practices
14 changes to policies/procedures
11 changes to infrastructure

2

formal undertakings from services to take specific actions in response to complaints

Our role and approach

The Mental Health Complaints Commissioner (MHCC) has broad functions under the *Mental Health Act 2014* (the Act) to identify, analyse and review quality, safety and other issues arising out of complaints, and to provide advice and make recommendations for service and system improvements. In addition, the MHCC has the power to invite and accept a formal undertaking from a mental health service to take specific actions to achieve required changes in practices and service improvements. (See discussion in 'Safeguarding people's rights through complaints' on page 12 and complaint example on page 44.)

Our office identifies critical issues of safety and quality arising from people's experiences of mental health services to make recommendations that will address risks and breaches of people's rights. Listening to the voices and views of consumers and their families, carers or other support people is critical in making these recommendations that will improve the quality and safety of mental health services and ensure that people have better experiences when they access mental health treatment.

This year mental health services continued to proactively identify areas for improvement after being contacted by the MHCC. In other instances, service improvements were made as a result of discussions between the service and the person who raised their concerns facilitated by our office as part of the resolution process. Many service improvements were also the result of formal MHCC recommendations.

Service improvements and recommendations to services

In 2018–19 the MHCC recorded 88 service improvements across 37 complaints and investigations, similar to most years. A higher number of service improvements and recommendations were recorded in 2017–18, which included those made as a result of the MHCC's sexual safety report and project.

Of the 88 service improvements, 37 related to training and feedback provided to staff, 26 related to changes to service practices, 14 related to changes to policies and procedures and 11 related to infrastructure changes (see Figure 17).

In 2018–19 the MHCC also made 72 formal recommendations to services, mostly to review practices, policies and procedures. Some of these recommendations resulted in the service improvements noted above. However, some recommendations, particularly those made through investigations, were complex and require more careful deliberation and considered implementation by mental health services. As such, some service improvements made as a result of these recommendations will be reported in 2019–20.

Practices

Changes to service practices related to several of the mental health principles as follows:

b Promote recovery

- recruitment of additional staff, including nursing staff to support safety for vulnerable consumers, specialist practitioners including gerontology nurse practitioners, and additional staff to improve timely responses to complaints
- increased visits by psychiatrists to aged care services
- improvements to discharge planning processes
- increasing oversight of consumer risk and safety issues, to ensure strategies to respond have adequate oversight
- developing additional information materials for consumers.

c Ensure supported decision making

- recruiting peer support workers to improve communication between consumers and clinicians
- involving consumers in processes across the unit, including ward rounds and team meetings.

e Promote rights, dignity and autonomy

- addressing consumers' lost or stolen property issues at staff meetings
- assessing the adequacy of the toiletries a consumer brings with them to the inpatient unit and providing the consumer with a toiletry pack if required.

g Recognise and respond to individual needs

- developing information sheets or booklets for consumers that provide information about people's right to safe and inclusive services
- ensuring the needs of LGBTI consumers are individually considered, particularly with respect to safety and bedroom allocation.

k Involve carers

- introducing a carer peer support program to assist staff and support families when consumers prefer their families not to be involved
- providing treatment plans to both consumers and carers (with consent).

Policies and procedures

Recommendations and changes to policies and procedures related to several of the mental health principles as follows:

a Provide least restrictive treatment

Actions taken in this area included reviewing policies and procedures particularly in relation to the use of restrictive interventions:

- to ensure that the requirements of the Act and Chief Psychiatrist Guidelines in relation to restrictive interventions are met including in relation to ensuring de-escalation techniques are used, ensuring consumers have an opportunity to formally debrief following the use of a restrictive intervention, ensuring that any use of a restrictive intervention is reviewed and that this process includes consumer input, and to meet minimum staff requirements for the use of restraint
- in the emergency department, including prioritising mental health assessment of consumers who are restrained or who may be at risk of restraint, and developing alternative strategies for responding.

Note: As of 30 June 2019, the MHCC was completing two investigations with detailed recommendations relating to the use of restrictive practices and finalising two undertakings from services which deal with the legislative requirements for the use of bodily restraint. These recommendations and undertakings will also include the review of policies, procedures and practices to uphold the mental health principle of least restrictive treatment.

Actions also related to review of policies and procedures to ensure that consumers are assessed and treated in the least restrictive way possible, including by seeking collateral information from other treating health professionals, families and carers that may inform the assessment of whether a less restrictive form of treatment is possible (for example, treatment by a private mental health service).

b Promote recovery

Actions taken in this area included reviewing policies and procedures:

- to support provision of trauma-informed care, including working with consumers to identify strategies that will help them feel safer during inpatient admissions and ensuring debriefing and psychological support is available to consumers who have experienced significant events
- to improve handover procedures, to ensure better communication between all key clinicians
- to improve discharge and transfer procedures to ensure all relevant clinical documentation is included, to ensure that consumers are always provided with a discharge summary, and to ensure that changes in medication are communicated to other medical practitioners involved in the consumer's care
- to ensure that a consumer who re-presents to the emergency department within seven days with the same concerns will be reviewed by a psychiatric registrar or consultant psychiatrist
- to ensure that investigations into alleged assaults by staff are undertaken by people who are independent of the unit, and that consumers are supported to participate in the investigation

- to respond to alleged assaults by other consumers, including strategies for re-establishing safety, providing medical review and psychological support, ensuring appropriate follow-up by providing advice on reporting incidents to police, providing open disclosure and outlining requirements for staff to document and report incidents to senior staff.

c Ensure supported decision making

Actions in this area included reviewing policies and procedures to enhance supported decision making and the development and use of advance statements, for example to ensure that information in advance statements is clearly accessible to all staff. Actions also included review of policies and procedures to ensure that consumers are provided with information about medication changes including side-effects.

e Promote rights, dignity and autonomy

Actions in this area included reviewing policies and procedures to ensure that:

- services provide a written statement of rights as well as a verbal explanation of rights under the Act in a timely manner, and that information about rights is provided on an ongoing basis
- patients receive reports related to an MHT hearing at least 48 hours prior to the hearing, in accordance with the requirements of the Act

- consumer consent is sought to disclose information to third parties
- consumers who are to attend a police interview receive adequate support including post-interview supports, communication with carers and advice about accessing a legal practitioner.

f Recognise and respond to medical needs

Actions in this area included reviewing policies and procedures to ensure that:

- timely medical examinations are offered in response to allegations of assault or misconduct by staff, physical assault by another consumer, or following the use of restrictive interventions
- consumers' physical health issues receive timely intervention, including by ensuring staff are aware of how to access on-call staff, and ensuring that consumers are transferred to receive medical care where required
- if a medical device is removed due to risk concerns, sufficient consideration has been given to the health consequences of removing the device, exploring alternatives, and discussing these with the consumer
- enough appointments are available with general medical staff
- following serious near-miss events, in-depth reviews are led by a senior manager to identify what happened, why the incident occurred and what can be done to prevent reoccurrence
- incident reports are completed in relation to falls in accordance with the Chief Psychiatrist's guidelines.

g Recognise and respond to individual needs

Actions included reviewing policies and procedures to:

- include requirements for cultural sensitivity
- ensure consistency with the recommendations in the MHCC's *The right to be safe* report, in particular investigation standards and ensuring it is clear that sexual activity or any breach of another person's sexual safety is unacceptable.

k Involve carers

l Recognise, respect and support carers

Actions included reviewing policies and procedures to ensure that:

- clear expectations are outlined for engaging with families and providing detailed feedback and open disclosure following an incident or adverse event
- contact details for family members and carers whom consumers wish to be involved in their treatment are readily accessible, and that the family member/carer is involved at all relevant stages of treatment or when an incident occurs.

Staff training

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

a Provide least restrictive treatment

This included training on:

- training for medical staff on the statutory requirements for making a compulsory treatment order, the mental health principles, and the Charter, as well as the practices and approaches required to ensure that treatment is provided in the least restrictive way possible
- the use of restrictive interventions
- identifying and reporting allegations of restrictive practices, assaults, abuse, neglect and unexplained injuries in aged care settings
- the right to communicate and requirements relating to decisions made under the Act to restrict an inpatient’s communication.

b Promote recovery

This included training on:

- the Safewards model
- open disclosure following a significant event
- performance management training for team leaders
- interacting with and responding to the needs of consumers
- responding to consumers presenting to the ED with thoughts of suicide
- avoiding medication errors
- responding to feedback in a timely manner.

e Promote rights, dignity and autonomy

This included training on:

- ensuring that consumers’ rights, dignity and autonomy are protected during all aspects of assessment and treatment, and acting to ensure their privacy
- documentation of consumers’ property and personal medication
- responsiveness to use of inappropriate language by consumers.

f Recognise and respond to medical needs

This included training on:

- the use of medical on-call services
- reporting and escalation of injuries and accidents to management and the multidisciplinary team at handover and through incident reporting systems.

g Recognise and respond to individual needs

This included training on:

- the use of interpreters to assist in the orientation of consumers from CALD background
- gender sensitivity, including interactions relating to feminine health and hygiene
- working with the LGBTI community.

k Involve carers

l Recognise, respect and support carers

This included training on responding to the concerns of and communicating with families and carers

Feedback to or counselling of individual staff was also provided in response to several complaints, accounting for the large proportion of service improvements that fell into this category.

Infrastructure changes

Infrastructure changes included:

b Promote recovery

- allocation of a room in an ED to facilitate more timely mental health assessments
- additional security monitoring systems
- refurbishment of inpatient units and outdoor spaces.

g Recognise and respond to individual needs

- increased signage on inpatient units about appropriate language
- swipe-card access to bedrooms to improve safety and privacy.

Recommendations to the Secretary of DHHS (2018–19)

In 2018–19 the MHCC made five recommendations to the Secretary of DHHS as a result of systemic issues identified through complaints and investigations.

Aged persons’ mental health residential care facilities

Three of the recommendations made to the Secretary this year arose from issues identified by a confidential complaint about the treatment and care of residents of an aged persons’ mental health residential care facility. An overview of the complaint, including the recommendations made to the Secretary, has been included in this report (page 44). In summary, the MHCC recommended that the Secretary:

- take steps to provide for a regulatory framework for the oversight and reporting of the use of restrictive interventions in aged persons’ mental health residential care facilities
- take steps to ensure that staff of these facilities receive appropriate training in relation to identifying and reporting allegations of abuse, neglect, unexplained injuries, and alleged or suspected reportable assaults, and identifying and reporting restrictive practices
- review the model of care and clinical governance arrangements for the facility having regard to the issues raised in the complaint and best practice for aged care mental health services.

Adequacy of training for staff authorised to make Assessment Order

A further recommendation made by the MHCC in 2018–19 was that the Secretary and the Chief Psychiatrist consider the adequacy of the training provided to staff of designated mental health services (medical and non-medical staff) who are authorised to make Assessment Orders under the Act.

This issue was highlighted by an investigation completed by the MHCC in 2018–19. The consumer was placed on an Inpatient Assessment Order by a Hospital Medical Officer, and the order was revoked the next day when the consumer was reviewed by the Consultant Psychiatrist. The investigation found that staff did not seek collateral information from the consumer’s general practitioner or private psychiatrist and did not explore alternatives to an inpatient admission. A further finding was that the Hospital Medical Officer did not receive adequate training in relation to the role the practitioner would be expected to perform to make Assessment Orders.

The MHCC also continued to deal with another complaint in which the service acknowledged that the consumer was not examined within 24 hours by a medical practitioner or mental health practitioner when an Assessment Order was made in the community, in breach of the requirements of the Act. The recommendation to the Secretary is one of a number of actions taken by the MHCC in response to this complaint.

Process and framework for the care and treatment of ‘high-risk’ consumers with dual disabilities and complex needs

The MHCC dealt with a complaint in 2018–19 that highlighted the barriers to appropriate treatment and care for consumers with multiple and complex needs requiring collaboration by multiple agencies, especially for consumers assessed as being at high risk of causing harm to themselves or others. The consumer made a complaint to the MHCC after he experienced lengthy periods of seclusion in a mental health service. All services involved in his treatment and care agreed the facility in which he was detained was unsuitable for him. Although he was entitled to a NDIS-funded package the MHCC identified that a key barrier to his discharge from the facility was that there was no agency with overall responsibility for co-ordination, escalation and oversight of his care planning.

The MHCC made a recommendation to the Secretary that the department review the processes and framework for the care and treatment of ‘high-risk’ consumers with dual disabilities and complex needs who are detained in unsuitable facilities and/or subject to prolonged use of restrictive interventions, including:

- a) the need for clear processes and a framework for centralised co-ordination, escalation and oversight of care planning
- b) consideration of a model similar to the ‘High-Risk Complex Care Child and Youth Panel’ recently proposed by the Victorian Auditor-General’s Office
- c) processes to ensure that one agency has overall responsibility for care planning and co-ordination, including chairing multi-agency case conferences
- d) consideration of timelines for the development of discharge plans or plans for reduction of the use of restrictive interventions.

Elizabeth's complaint

Background information

The MHCC has jurisdiction to deal with complaints about aged persons' mental health residential care facilities if they are operated by a designated mental health service. These residential facilities are subject to the Commonwealth *Aged Care Act 1997* and funded by the Commonwealth (like nursing homes) and receive additional funding from the Victorian Government.

At the time of this complaint the Aged Care Complaints Commissioner also had jurisdiction to deal with concerns about these residential facilities. The Commonwealth Aged Care Quality and Safety Commission, established on 1 January 2019, replaced the Aged Care Complaints Commissioner and the Australian Aged Care Quality Agency.

What the person who made the complaint told us

Elizabeth made a confidential complaint to the MHCC that raised serious allegations of verbal and physical abuse and neglect of residents of an aged persons' mental health residential care facility, including concerns about the use of restrictive interventions. Elizabeth provided extensive documentation to the MHCC about her observations of how staff had treated residents. She also raised her concerns directly with the service and with other agencies.

Mental health principles, rights and responsibilities that apply to complaint

The provisions regulating the use of restrictive interventions in Part 6 of the Mental Health Act do not apply to aged persons' mental health residential care facilities. However, the mental health principles do apply, including that people receiving mental health services should have their rights, dignity and autonomy respected and promoted (s 11(e)).

A number of Charter rights are also raised by the allegations, including the right to protection from cruel, inhuman or degrading treatment (s 10(b)) and protection from unlawful or arbitrary interference with privacy (s 13(a)).

MHCC initial assessment and action/steps taken – summary

As an initial response, the MHCC made a notification to the Australian Health Practitioner Regulation Agency (AHPRA) about staff members who were the subject of allegations. The MHCC deferred its assessment of the substance of the complaints until after the completion of an investigation commissioned by the service about the quality of care and workplace culture and an investigation by the Chief Psychiatrist about the clinical care and safety of residents.

Example complaint

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

Outcomes/resolution

Actions to respond to specific concerns about the service and staff

Following our review of the investigation reports we remained concerned that the service-commissioned investigation had not adequately considered some of the specific allegations relating to abuse and neglect of residents. The MHCC then took the following steps:

a) Visit to service: The Commissioner met with the chief executive officer of the service and senior staff to discuss our assessment of the issues and met with some residents at the facility.

b) Undertaking: The MHCC negotiated with the service to make an undertaking under s 243(4)(e) of the Mental Health Act to take several actions, including to:

- report to the Chief Psychiatrist the use of any restraint (bodily or mechanical) on residents of the facility for a six-month period
- provide to the Chief Psychiatrist a monthly summary of all clinically related incidents about residents for the same period
- provide training for staff who provide care to residents about identifying and responding to elder abuse, identifying and reporting incidents of alleged or suspected reportable assaults as required by the Aged Care Act and identifying and responding to restrictive practices.

c) Referral of concerns regarding practitioners to AHPRA:

The MHCC made a formal referral to AHPRA explaining our concerns that the allegations about a number of health practitioners had not been adequately investigated and that there was a potential risk to residents and the public.

d) Open disclosure process:

The MHCC wrote to the residents who the person alleged were subject to abuse and neglect, and/or their family members, inviting them to be part of an open disclosure¹⁴ process by the service facilitated by the MHCC. The MHCC facilitated three open disclosure meetings as part of this process. These meetings provided the opportunity for residents and their family members to understand the nature of the allegations and the steps that would be taken to address the individual residents' experiences and to improve their future care.

Systemic issues

The MHCC also decided that the complaint raised several systemic issues about the treatment and care of residents of aged persons' mental health residential care facilities. Accordingly, the MHCC made several recommendations for service improvement to the DHHS Secretary as follows.

a) Use of restrictive interventions

The use of restrictive interventions (restraint and seclusion) in aged mental health inpatient units is governed by Mental Health Act. In contrast the use of restrictive interventions in aged persons' mental health residential care facilities is not subject to regulation by the Act, even when the facilities are operated by a designated mental health service.

The MHCC advised the Secretary that our assessment of Elizabeth's complaint is that it highlighted the gaps in the oversight and reporting of restrictive interventions of residents of aged persons' mental health residential facilities in Victoria. We noted that the absence of an adequate regulatory framework for the use of restrictive interventions in aged care under Commonwealth laws has been documented comprehensively elsewhere, including in the Carnell/Paterson report commissioned following the failures identified at Oakden Older Persons Mental Health Service in South Australia,¹⁵ and that the lack of regulatory oversight was particularly concerning given the vulnerability of residents of aged persons' mental residential care facilities. Accordingly, the MHCC recommended that the Secretary take steps to provide for a regulatory framework for the oversight and reporting of the use of restrictive interventions in aged care mental health services, whether pursuant to Victorian laws or by advocating for amendment to the Commonwealth regulatory framework in relation to aged care services.

b) Staff training regarding allegations of abuse and mandatory reporting

The MHCC also identified issues relating to the adequacy of existing training for staff of aged persons mental health residential care facilities about identifying and reporting allegations of abuse and neglect of residents. Under the Aged Care Act allegations or suspected reportable assaults must be reported to the police and the Commonwealth Department of Health. Our assessment was that some of the observed incidents met the criteria for mandatory reporting pursuant to these provisions and were not reported.

Accordingly, the MHCC recommended that the Secretary take steps to ensure staff of aged care mental health services receive appropriate training in how to identify and report allegations of abuse, neglect, unexplained injuries and alleged or suspected reportable assaults, and in identifying and reporting restrictive practices.

c) Model of care and clinical governance

A further issue related to the appropriateness of the arrangements for the model of care and clinical governance of the facility referred to in Elizabeth's complaint. The MHCC recommended that the Secretary review the model of care and clinical governance arrangements for the facility, having regard to the issues raised and best practice for aged care mental health services.

The Secretary responded to the MHCC in January 2019 to advise that work was being undertaken to develop a 'best practice' model of care (including the reporting of restraint and assaults) following consultation with service providers and aged care experts. The Secretary also advised that the Chief Psychiatrist will require health services to provide training on the recommended topics on a recurrent basis to staff of aged persons' mental health residential care facilities. The Secretary also indicated that further consideration would be given to the model of care and governance arrangements at the facility.

14 Open disclosure: An open discussion with a patient about an incident(s) that resulted in harm to that patient while they were receiving healthcare. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure is a discussion and an exchange of information that may take place over several meetings. (Commonwealth of Australia 2013, *Australian Open Disclosure Framework*, Australian Government, Canberra)

15 Carnell K, Paterson R 2017, *Review of national aged care quality regulatory processes*. Available from: www.health.gov.au/sites/default/files/review-of-national-aged-care-quality-regulatory-processes-report.pdf

Reporting on recommendations made in previous years

We continue to work closely with the department about recommendations made in previous years and in 2018-19, we established regular governance meetings with the department to discuss and monitor responses to our recommendations.

Sexual safety recommendations

We continue to work with the department and Office of the Chief Psychiatrist through the meeting discussed above, to monitor progress against the recommendations of *The right to be safe*. We acknowledge that many actions are underway and continue to highlight the importance of an overarching strategy to ensure sexual safety in mental health acute inpatient units, and a policy directive for mental health services about how to prevent and respond appropriately to sexual safety breaches.

Mental health service responses

In 2018-19, the MHCC sought responses from designated mental health services about actions taken in response to *The right to be safe* recommendations. All services responded, with most indicating that some actions had been met, some were in progress and others in planning stages. The approach to implementation varied across services, with some taking an in-depth approach to reviewing policies and programs to better ensure sexual safety, and others adjusting existing approaches.

We discuss and monitor actions taken in response to the recommendations in our regular meetings with services and use this information to inform our assessment and resolution of complaints involving sexual safety issues. We are looking at the best ways of sharing the themes from these responses to inform the broader work being undertaken to implement *The right to be safe* recommendations.

Update on MHCC Recommendations to the Department of Health and Human Services

The Department acknowledges the positive outcomes through successful partnership of the MHCC and the Mental Health Branch. Work is underway in a vast range of areas related to the Commissioner’s work and recommendations. The Royal Commission into Victoria’s Mental Health System will provide important context for joint work and implementation into the future.

The Department is committed to enabling a mental health service system in which everybody feels safe and supported. Significant progress is being made to improve sexual safety in the Victorian mental health system in line with the directions of the MHCC’s report ‘The Right to be Safe’. This is being overseen by a newly-established Mental Health Sexual Safety Committee. Consumers, carers and the MHCC are represented on this Committee.

Compliance with sexual safety reporting to the Office of the Chief Psychiatrist is well established and the office is engaging actively with services on matters that are being reported. A risk assessment framework is now under development. The framework will encourage a model based on individually tailored safety plans, which will take into consideration sexual safety risks to others and the potential vulnerability of each consumer. The Chief Psychiatrist’s discharge planning guideline is currently being reviewed. The updated guideline recognises that consumers who have experienced sexual trauma or safety incidents, particularly in mental health services, have specific discharge planning needs. A framework guiding the delivery of trauma-informed care and practice in mental health services is also under development.

The Safewards model, designed to improve safety for consumers and staff, will be fully implemented to all mental health inpatient units in Victoria in 2020. Inhouse training has been delivered to all services. The Mental Health Intensive Care (MHIC) and Nursing Observations Project will deliver training through the Centre for Psychiatric Nursing at the University of Melbourne. The MHIC Framework prioritises assessing risk and vulnerability regarding sexual safety.

The Department has commenced a trial of Safewards in Emergency Departments. The Safewards model has been proven to reduce the use of restrictive interventions in acute mental health inpatient settings and this trial is intended to test if the model can be successfully translated into emergency medicine settings and achieve the same reductions in restrictive interventions.

The Chief Psychiatrist Guideline: Electronic communication and privacy in designated mental health services was published this year, with input from the MHCC.

Contributions to consultations, projects and advisory groups

We take part in a wide range of sector consultations, forums and other activities. This enables us to identify emerging themes and opportunities for service improvements, and to contribute what we have learned from complaints made to our office to broader initiatives at both the state and national levels.

Consultations and projects

- In 2018–19 we provided input into 27 key projects and consultations including:
- input to national mental health projects and consultations including National Mental Health and Suicide Prevention Information Priorities, and the development of a certification framework for the Digital Mental Health Services Standards
 - contributions to work by the Australian Human Rights Commission, Commonwealth Ombudsman and Victorian statutory bodies on the implementation of the *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)*
 - consultations with the NDIA and NDIS Quality and Safeguards Commission on NDIS transitional arrangements and issues identified in complaints about NDIS-funded supports for people with psycho-social disabilities
 - contributions to statutory reviews and audits including VAGO’s audit on access to mental health services, and review of the provisions for reportable deaths in the regulations of the *Coroners Act 2008*
 - consultations on the development of strategic frameworks, including the DHHS Mental Health Lived Experience Framework and the DHHS Community Services Quality and System Architecture Project
 - input to the Victorian Agency for Health Information’s work on the VHIMS Minimum Data Set
 - consultations on proposed changes to legislation and regulations, including amendments required to improve information sharing in line with the recommendations of the *Targeting Zero* report, and proposed legislative amendments related to transitional arrangements for the NDIS
 - input to violence prevention strategies, including the DHHS Family Violence Primary Prevention Strategy and Victoria Police’s Family Violence Report
 - consultations on the Royal Commission into Victoria’s Mental Health System’s terms of reference and processes.

Advisory groups

- We also participated in seven key advisory and reference groups to support related areas of work. These are the:
- Department of Health and Human Services (DHHS) Progress Measures Working Group
 - DHHS Lived Experience Advisory Group (Associate member)
 - Office of the Chief Psychiatrist (OCP) Human Rights Project Advisory Group
 - OCP Sexual Safety Committee
 - OCP ‘Working together with Families and Carers’ Implementation Working Group
 - Safer Care Victoria Mental Health Clinical Network Insight Subcommittee
 - Victorian Ombudsman OPCAT Investigation Advisory Group.
- Further information about our contributions is provided in Appendix 2 (see page 63).

Example complaint

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

Maria’s complaint

Summary

Maria called the MHCC to make a complaint about the lack of trauma-informed and gender-sensitive care she had received during an admission to a mixed-gender acute inpatient unit.

What Maria told us

During a recent inpatient admission, Maria had initially been admitted to the intensive care area, where the other consumers were men. Maria had a history of trauma, which she had disclosed to the mental health service. Maria told us that being in the intensive care area had felt very unsafe for her.

Maria was later moved to the open unit and was accommodated in the women’s corridor. However, Maria told us that the women’s corridor was unlocked, and male patients frequently crossed the women’s corridor to reach communal living areas. Maria was also concerned that the women’s lounge was small, airless and uninviting. Maria stated that she was at times the only woman in the unit and that this had been very difficult for her.

Maria told us that she felt sexually harassed by some male co-consumers by the way in which they were looking at her and following her around the unit. Maria told us that she had raised her concerns with service staff during her admission but reported that staff did not take any action to support her.

After her discharge, Maria called the MHCC, and we accepted her complaint and supported her to put it in writing.

How the mental health principles applied to the complaint

The Mental Health Act protects the rights of people receiving mental health treatment from a public mental health service. Anyone accessing care and treatment should expect the service’s approach to be guided by the principles in the Act.

The principles most relevant to Maria’s complaint are:

b Promote recovery
Persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life.

e Promote rights, dignity and autonomy
Persons receiving mental health services should have their rights, dignity and autonomy respected and promoted.

g Recognise and respond to individual needs
Persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to.

What do the mental health principles mean for Maria?

Mental health services have a duty to ensure the sexual safety of people accessing acute mental health inpatient treatment and to respond effectively to any breaches. The mental health principles mean that Maria had the right to have her individual needs as a woman with a history of trauma responded to in her treatment and care. This would mean proactively engaging with Maria about what was necessary for her to be able to feel safe during her admission, listening to Maria’s reports of feeling unsafe and working with her to develop strategies to ensure she felt safe.

Our involvement

With Maria’s consent, we provided her complaint to the service. We assessed that Maria’s complaint raised concerns about whether the service had provided gender-sensitive and trauma-informed care, and whether Maria’s rights, dignity, autonomy and individual needs had been recognised and responded to. We assessed Maria’s concerns in light of the recommendations of *The right to be safe* report, in particular recommendations involving trauma-informed care as a preventative strategy, trauma-informed responses to reported sexual safety breaches, and infrastructure.

Some of the outcomes Maria was seeking from making her complaint were for:

- trauma histories, particularly women’s histories, to be better understood as a critical part of the broader context of people’s mental health challenges
- safe, women-only spaces to be available in mental health services.

We worked with the service to develop a response that respected Maria’s experience and focused on her experiences of her interactions with service staff, as well as future actions that could be taken to prevent other consumers having similar experiences. We emphasised the importance of responding to people’s reports of sexual safety breaches, including sexual harassment and feeling unsafe, together with the person to make sure that the strategies used are effective. In Maria’s situation, having men frequently enter the women’s corridor made the environment untherapeutic and distressing, and made it difficult if not impossible for her to feel safe and supported in the inpatient unit. Being in the intensive care area was also not a good solution for Maria because, consistent with the reports of many women, Maria felt even less safe in the small, enclosed area where she was often the only woman. Both environments were clearly contrary to the mental health principles of promoting the ‘best possible therapeutic outcomes’, responding to Maria’s individual needs and upholding her right to be safe.

Outcomes

After several discussions, the service advised that they intended to provide additional allied health staff for the unit to better support consumers, improve the amenity of the current women’s-only lounge and consider gender and safety in future infrastructure works to address the issue of men crossing the women’s corridor.

As a direct result of Maria’s complaint, the service also revised and updated their practice guidance to staff about gender and sexual safety to better incorporate the themes and issues raised in Maria’s complaint and to improve staff responses to reported sexual safety breaches.

After consultation with DHHS, the MHCC made a formal recommendation that the service review the layout of the unit to determine a more suitable women’s-only corridor and, if necessary, seek support from DHHS to make any required changes to infrastructure.

Maria agreed to closing the complaint on the basis that the service had reviewed its practice and policies about gender safety and was progressing discussions about making changes to the internal layout of the inpatient unit to ensure gender and sexual safety. The MHCC will continue to work with the service through regular meetings about further improvements that can be made to the guidance provided to staff about ensuring sexual safety and responding to sexual safety breaches.

United Nations Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)

In 2018–19 the Victorian Ombudsman initiated an OPCAT style investigation to review the practices of ‘solitary confinement’ of young people in youth justice centres and prisons and invited the MHCC along with other relevant statutory bodies and organisations to contribute to this investigation. This was of particular interest to the MHCC given our role in dealing with prisoner complaints as well as our work in highlighting the implications of OPCAT for the use of restrictive interventions, including seclusion, in mental health services. The Commissioner participated in the Victorian Ombudsman’s Advisory Group for this investigation. The Deputy Commissioner was seconded to the Victorian Ombudsman to be the mental health advisor on the inspection team for the duration of the investigation.

Through our involvement in this investigation, the MHCC identified the pressing need for appropriate mental health treatment for young people and prisoners assessed as being at high suicidal risk in these settings and the extremely harmful nature of the practices of ‘solitary confinement’. The MHCC contributed to the Victorian Ombudsman’s report findings and recommendations on these critical issues. The MHCC’s involvement in the OPCAT investigation was also instructive for our assessment of complaints about mental health treatment in prisons, and in thinking ahead about how the implementation of OPCAT inspections of mental health services will further highlight the actions required to reduce and eliminate restrictive interventions and other practices that may be experienced as cruel, inhuman, or degrading.

Driven by lived experience:

Strategic advice and submissions

Five members of the Advisory Council (three consumers and two carers) worked with MHCC staff in 2018–19 to develop our approach for our initial submission to the Royal Commission into Victoria’s Mental Health system. Their lived experience and advice will continue to drive further input from the MHCC.

Submissions and reports

In 2018–19 we provided formal feedback on five matters. These were the:

- Coronial Council review of reportable deaths in Victoria
- National Safety and Quality Health Service (NSQHS) user guide for health services providing care for people with mental health issues
- Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health
- Royal Commission into violence, abuse, neglect and exploitation of people with disability – terms of reference
- Royal Commission into Victoria’s Mental Health System – terms of reference.

Participation in national meetings

We participate as a member of the health complaints and disability commissioners’ group to address common issues across jurisdictions, including approaches to complaints about mental health services and issues associated with the transition to the NDIS. We also participate as a member of the mental health commissioners’ group and regularly collaborate and share information on service and systemic improvement initiatives across jurisdictions.

Our priorities

Over the coming year we will continue to prioritise our function of identifying issues of quality, safety and rights from complaints and promoting service and systemic improvements. After five years of operation, the MHCC holds a wealth of data (over 16,000 complaints¹⁶) that provide vital insights into people’s experiences with the Victorian mental health system and highlight areas that require attention to uphold rights, embed the principles of the Act and improve services. The Royal Commission into Mental Health provides the once in a generation opportunity for the MHCC to also contribute these insights to the Commission’s task of making recommendations for broad ranging systemic reforms and to address the underlying causes of many of the complaints about people’s experiences of the current system.

16 These includes complaints made directly to the MHCC and local complaints reported by services for five years from 2014–15 to 2018–19.



Education and engagement

Our role and approach

Under the Mental Health Act, the MHCC must ensure the process for making a complaint is accessible and available to all Victorians.

We work with consumers of public mental health services, their families and carers to ensure people understand their right to make a complaint and feel confident and safe to raise their concerns either directly with the service or with our office. Our education and engagement work also focuses on promoting awareness of people’s rights and the mental health principles, and the safeguarding role and functions of our office.

The Act also requires us to provide mental health services with information and education about their responsibilities and requirements when responding to complaints. We work directly with services to create a culture in which people are supported to speak up about their concerns, and where complaints are seen as central to treatment and as real opportunities for service improvement.

Highlights

Sector engagement

In 2018–19 we delivered a broad range of education and engagement activities for consumers, families, carers, services and other stakeholders on the role of our office, safeguarding rights and effective approaches to resolving complaints. We reached 2,542 people through 83 direct education and engagement activities. In this period, we focused on engaging with larger audiences through presentations at conferences and forums and limited our broader awareness-raising activities due to the demands of our resolutions work. With additional resources in the coming year, we will be renewing our approaches to these activities, along with targeted education activities on complaint themes and effective approaches to resolving complaints.

Training and presentations

In 2018–19 we delivered 20 presentations and education sessions including:

- presentations at national conferences including keynote presentations at the Towards Eliminating Restrictive Practices (TERP) 12th National Forum, Women in Public Leadership Summit, and sessions at the TheMHS conference and the Equally Well National Symposium
- presentations at Victorian conferences and forums including the Grampians Mental Health Conference, Safer Care Victoria’s Mental Health Clinical Network Strategic Planning Day, Chief Psychiatrist forums on sexual safety and on advance statements and nominated persons
- presentations at key sector events including the Women’s Mental Health Network Victoria 30th Anniversary and Tandem Carers Awards event
- education sessions on the role of the MHCC and themes from complaints to the VMIAC Consumer Consultant Forum, Mind Carer Forum and the Office of the Public Advocate Victoria Community Visitors Training Day
- presentations and training to staff of clinical mental health services including the Western Victorian Mental Health Learning and Development Cluster Program and Monash Health Youth Stream clinicians.

See Appendix 2 for details.

Overview

Education and engagement activities

20

education sessions and presentations reaching

1889

people, including:

- presentations at conferences and forums, and to mental health services and other stakeholders, on quality and safety issues identified in complaints
- training sessions on effective responses to complaints

27

consumer and carer engagements reaching

223

people, including:

- contributions to consumer and carer events and projects
- meetings and consultations to promote awareness, input and feedback on our work
- information sessions to consumer and carer advisory and support groups

370

people reached through information stands at four expos and conferences including:

- events promoting awareness of mental health services to consumers and carers
- a conference addressing the needs of people transitioning to NDIS-funded supports

10

service visits and meetings to:

- discuss local and statewide data trends, local complaints handling processes and service improvements and existing complaints and recommendations made to the service
- tailor education sessions to meet service requirements
- review complaints handling policies and procedures and provide advice

22

sector events to:

- address key quality and safety issues and developments in mental health services and related sectors, approaches to complaint resolution and investigations, and human rights

55

other stakeholder meetings and events to:

- support and develop our work and ensure effective referrals and working relationships
- contribute to broader mental health service improvements and reforms

Communications

Web

16744

sessions

38440

page views

Facebook

3060

followers

2977

page likes

Twitter

1203

followers

LinkedIn

618

followers

The Mental Health Services Conference (TheMHS) 2018

For TheMHS conference in Adelaide, our Commissioner joined other mental health commissioners from Australia and New Zealand in a symposium on their roles and contributions across different jurisdictions, mental health reforms and innovations. The Commissioner also delivered a presentation on the compelling insights complaints provide about mental health service cultures and how we have identified key safety and quality issues in complaints, highlighting sexual safety and our *The right to be safe* report.

Towards Eliminating Restrictive Practices (TERP) 12th National Forum, Hobart

In 2018 the Commissioner, Deputy Commissioner and Senior Adviser, Lived Experience and Education, all presented at the 12th TERP forum. The Commissioner delivered a keynote speech in which she gave the Australian perspective on the international obligations arising from the ratification of the OPCAT agreement (*Optional Protocol to the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment*). She particularly focused on how this would relate to the practice of restrictive interventions within mental health service settings and the obligations of services in this context.

The Deputy Commissioner and Senior Advisor, Lived Experience and Education delivered a paper entitled *Complaints: a vital window into consumer experiences of restrictive practices*, which explored what people’s experiences tell us about the use of restrictive practices in mental health services. They spoke about how services can use this information to influence service and system improvement and outlined the way the MHCC works with people and services to resolve complaints. The Senior Advisor Lived Experience and Education also reflected on the value of developing advance statements as a way of working with the service to consider alternatives to restrictive interventions in the future.

National Equally Well Symposium 2019

This important national symposium focused on the actions required to address the poor physical health outcomes for people living with mental illness. In her presentation, the MHCC’s Commissioner outlined themes from complaints data and the broad range of examples where people’s physical health, medical or disability needs had not been met by mental health services. She also discussed the ways in which complaints can identify key areas for attention and service improvement and highlighted services’ obligations under the mental health principles of the Act and Charter.

When delivering training or presentations, we focus on people’s rights under the Act and how the mental health principles apply to mental health service provision and complaint resolution. We also talk about people’s rights under the Charter and what this means for mental health service provision. In addition, we focus on quality and safety issues identified in complaints to the MHCC and in local complaints reporting data, and how complaints can help to prevent avoidable harms and improve services. We continue to highlight the findings and recommendations from *The right to be safe* report and to discuss the concerted actions that are required to ensure people’s sexual safety in acute mental health inpatient units.

In the Mental Health Expo, you played an important part in addressing the growing need regarding mental health awareness and related services.

Feedback from an attendee

You are bringing a difficult topic to the attention of our workforce. Despite this, feedback has been very positive and I think this reflects your outstanding skills in presenting messages that are difficult to hear, in a way that people can hear them.

Feedback on the MHCC’s presentation on *The right to be safe* report

Consumer and carer engagement

In 2018–19 we undertook 27 consumer and carer engagements reaching 223 people, where we promoted awareness of our role and were also informed by the lived experiences of consumers, families and carers. These activities included contributing to forums and meetings hosted by VMAC and Tandem Carers, learning from consumers and carers with expertise in areas such as peer support and co-production and supporting events that recognise the achievements and contributions of consumers and carers.

These included us presenting awards at Monash Health Mental Health Week, Action on Disability within Ethnic Communities ArtAbility, the VMAC Consumer Awards and Tandem Carer Awards. In addition, we have supported individual consumer advocate initiatives such as an interview with the Commissioner by a youth advocate in which she spoke about her role and *The right to be safe* report. The interview increased our social media reach to young people.

In addition, we reached 370 people through information stands at four key sector events, including many consumers and carers seeking information about the role of the MHCC and how to make a complaint.

See Appendix 2 for details.

Service engagement

We expanded our approach of meeting regularly with clinical mental health services in 2018–19, with 10 meetings held with seven services. These meetings have been valuable in working with service leaders on the most effective ways to resolve their current complaints. In addition, we have held meetings with four services on implementing recommendations from the sexual safety investigations we completed in 2017–18.

We have been able to engage in discussions about trends in complaints data relating to each service and to follow up on service improvements and recommendations that have been made through resolving individual complaints. We also use meetings to provide feedback about local complaints processes and work with the service on education regarding best practice in complaints handling. Throughout the year we have also used these meetings to review the improvements services are implementing in relation to sexual safety in their inpatient units in response to our *The right to be safe* report.

Within the MHCC we have had a renewed focus on integrating our resolutions work and education and engagement activities for services we have regular contact with. Resolutions staff who are dealing with complaints daily can have direct conversations with clinical staff and tailor the education to the specific service.

Participating in sector events

We attended 22 sector events including summits, symposia and forums to learn and contribute to discussions about key issues and developments in mental health service provision, complaint resolution and investigation, and the lived experiences of consumers and carers. Attending these events supports and develops our approach to working with consumers, families, carers and mental health services to effectively resolve complaints and influence system change.

These events included the:

- Australasian College for Emergency Medicine Mental Health Summit
- AHPRA National Registration and Accreditation Scheme research summit
- Chief Psychiatrist Quality and Safety Forums

- the launch of the DHHS information and resource paper on the Health and Wellbeing of people with intersex variations
- National Investigations Symposium for statutory and regulatory bodies
- TheMHS (Australia and New Zealand) Summer Forum: Community Mental Health Systems: Human Rights and Services – Special Rapporteur for the event
- Office of Public Advocate forums on safeguarding the rights of people with disabilities in respect to the NDIS and the justice system
- University of Melbourne Social Equity Institute and Forensicare event on ‘Policing and Mental Health’ with Michael Brown OBE
- Victorian Agency for Health Information first Annual Forum on using data to drive quality and safety improvements in health care
- Victorian Equal Opportunity and Human Rights Commission Human Rights Week Oration.

See Appendix 2 for details.

Submissions, consultations and contributions to projects

We contributed to 27 sector consultations, made submissions or provided formal feedback on five matters, participated in seven advisory and reference groups and contributed to 51 other stakeholder engagement meetings and events. Participating in these activities enables us to contribute to broader mental health service improvement and reform. These activities are discussed in ‘Promoting service and system improvement’, and a full list of activities is included at Appendix 2.

Driven by lived experience:
Explaining rights and responsibilities

In 2018–19 the MHCC’s Advisory Council worked with our Lived Experience Project team (led by the Senior Advisor, Lived Experience and Education) to develop a framework for how the lived experience of consumers and carers informs and drives our work. This project has been guided by the principles of co-production and co-design.

Advisory Council members told us that we could give clearer, more practical examples of what the Mental Health Act says about consumers rights and mental health services’ responsibilities, as well as the most common types of complaints. They have also worked with us to develop ways to share this information with as many consumers and carers as possible.

Consumer and carer members of the Advisory Council have informed the way we present example complaints in this report by providing ideas, advice and support to MHCC staff.

Promoting accessibility – Easy English resource

Another highlight of 2018–19 was launching our first Easy English resource on making a complaint. This resource is for consumers, families and carers who have an intellectual or psychosocial disability or who come from a culturally diverse background and have limited functional literacy in English. Working with Scope Australia and consumers with intellectual disabilities and limited functional literacy, we ran one-to-one consumer testing and created a series of drafts to make sure the language and specifically designed pictures were accessible and conveyed the key messages about complaints. Available on our website, the Easy English guide builds on our growing suite of accessible and inclusive information materials, including our 15 community language translations, our videos in Auslan and our resources for Aboriginal and LGBTI Victorians.

Renewing our approach to education and engagement

In 2018–19 the MHCC began redeveloping our education and engagement strategy, the implementation of which will be overseen by our Education and Engagement team.

In the coming year, we will increase our focus on meeting with senior staff and lived experience leaders in individual mental health services to work together to build better understanding of the issues in complaints both within the MHCC and to services, and to improve responses to complaints. As part of this targeted approach, we will ensure our staff are equipped with best practice tools to educate services and make informed recommendations for service improvement.

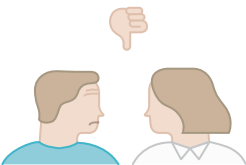
The work with all key priority population groups will continue, with a continuing focus on Aboriginal Victorians, LGBTI Victorians, people from culturally diverse backgrounds, people with disabilities and younger and older people. We will also continue to work closely with our Advisory Council to strengthen and expand the ways that our work is driven by the lived experience of consumers and carers.

Easy English resource

sample content



The Mental Health
Complaints Commissioner helps
people make a complaint.



A **complaint** is when someone
says they are not happy.



We help with complaints about
public mental health services
in Victoria.



You can complain if staff
do not listen to you.



Learning and growing our capability

I'm incredibly grateful for the information and the understanding and, as far as I'm concerned, all similar organisations should be run in the same way as how you've spoken with me, even briefly. Thank you once again, you've been a bit of a ray of hope in an otherwise hopeless feeling situation.

Caller

One of the MHCC's goals is to be an effective organisation that achieves positive change through our influence in the mental health system. We always look for ways to learn and develop our capability.

Our team

Our staff have a wide range of skills and experiences including lived experience of mental health services as consumers, family members and carers, and experience in mental health service delivery or programs, law, social work, nursing and dispute resolution.

Aligning with our functions under the Mental Health Act, the teams at MHCC are structured around four areas of focus:

- 1. Resolutions and Review
- 2. Specialist Advice and Investigations
- 3. Education and Engagement
- 4. Strategy and Quality.

Driven by lived experience:

Recruitment

A member of the MHCC Advisory Council with lived experience as a consumer or family member or carer is part of every interview panel at the MHCC. Including a council member with lived experience in the recruitment process helps us continue to build a workplace culture that values lived experience.

Driven by lived experience

We strive to ensure that the design, development and delivery of our processes, projects and approaches are all informed and driven by the lived experience of consumers, carers, families and people working in the mental health system. Our primary method for engaging with lived experience is by working with the members of the MHCC Advisory Council (see the Advisory Council section on page 10 for more detail), who:

- advise and guide us on our approaches to our work
- facilitate input from consumers, families, carers and service providers
- get involved in specific practice improvement and strategic projects
- participate in our recruitment processes.

We also conduct targeted consultations with other lived experience stakeholders in the sector to inform our strategic projects and our education and engagement activities. For example, in developing our first Easy English resource on making a complaint, we worked with Scope Australia and consumers with intellectual disability or limited English literacy to make sure the language and layout were appealing and accessible.

Examples of our work with the Advisory Council are included throughout this report. The Advisory Council's focus in 2018–19 has been to progress our 'Driven by Lived Experience' project. Informed by the principles of co-production, this project involves the Advisory Council and MHCC staff working together to:

- develop shared values to inform how we can be driven by lived experience
- form an evaluation framework to assess our performance against these values
- complete a gap analysis and prioritise areas for improvement
- document the approaches taken and lessons learnt through existing projects to develop a MHCC Lived Experience Framework
- outline a workplan for the MHCC future projects and improvements.

Driven by lived experience project: Developing shared MHCC values

As part of the 'Driven by Lived Experience' project, the MHCC Advisory Council and staff have been working together to review the MHCC values and principles that underpin our work. They have documented what being driven by lived experience means to them and what this looks like when it's working well. This has helped us identify gaps in our existing values and principles and new ways of expressing them that better represent the lived experience. The Advisory Council will continue to drive work on the MHCC's underpinning values and broader work on developing the lived experience framework in 2019–20.

Learning and improving from feedback

We seek feedback in a range of ways including through:

- our website and social media sites
- internal evaluations of our work and projects
- inviting feedback from people making a complaint
- responding to concerns and complaints that people raise with us about their experience with our office
- actively seeking feedback from services about our processes and approach.

We use the feedback we receive about our processes and approaches to make improvements to how we work.

Feedback about our complaints process

In 2018–19 we responded to concerns about the timeliness of our actions, the adequacy of steps taken by us, decisions we made, and interactions with our staff. In many cases the issue was resolved following a discussion with the Resolutions Officer dealing with the person's complaint. In other cases, the concerns were referred to our principal legal officer as part of our internal review process.

Where appropriate, after a further discussion with the person, we took additional steps such as seeking further information from the service being complained about. If we assessed that there were no further steps we could take to resolve the person's concerns, we provided a more detailed explanation of our reasons.

We also apologised to people when we should have taken a different or more timely approach. For example, in one matter, our internal review identified that the consumer had provided new information to us after her initial complaint, which we should have asked the service to consider. In another case we assessed that we should have taken more steps to try to contact a person before sending a letter advising of our decision to close their complaint.

We share complaints about the MHCC among staff to learn and make changes to our processes when we identify that we could improve our approach.

Our practice is also to advise people of their right to make a complaint about us to the Victorian Ombudsman if they wish.

Improving our approach

In 2018–19 we drew on the feedback we have received to continue to develop our practice, processes and approach.

Practice review

- Continuing the practice review we started last year, in 2018–19 we:
- worked with a consumer member of the Advisory Council to review how we write to people making a complaint
 - worked with staff and our Advisory Council to develop a language guide that ensures all our communications are consistent, inclusive, respectful and non-stigmatising
 - reviewed how we categorise complaints to make sure we can report people’s experiences more accurately and in more detail to better inform systemic improvements
 - implemented a new case management system, which has improved our reporting capabilities, enabled greater oversight of the progress of complaints and supported our Resolutions and Review team members to manage their high caseloads.

Driven by lived experience:
Letters to consumers

In 2018–19 an Advisory Council member with lived experience as a consumer worked closely with us to review the way we write to people who have made a complaint. This has resulted in clearer letters with less jargon, simplified formats and the use of succinct dot points that help with clarity about what has happened so far and what the next steps will be.

Our learning and development

- MHCC staff welcome regular opportunities for learning and development to help us improve our practice and better respond to people making a complaint. In 2018–19 we undertook training in areas such as:
- responding to people reporting alleged sexual assault or sexual harassment
 - the Safewards model of care
 - our obligations under the Charter of Human Rights and Responsibilities Act
 - confidentiality and privacy, information security and awareness, and our own health, safety and wellbeing.

All of our permanent Resolutions and Review team members are accredited under the National Mediator Accreditation Scheme or are working towards accreditation. They also participate in regular reflective practice sessions to improve both their individual and collective practice.

All our staff have regular opportunities to attend sector events and gain more understanding of best practice and new approaches in mental health, including learning from the clinical expertise or lived experience of others (see ‘Education and engagement’, page 52).

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Appendix 1:

Glossary

Feedback from consumers, families, carers and service staff guides the language of the MHCC’s communications, including in our annual reports. We use person-centred, recovery-oriented, inclusive language wherever possible. For example, we would refer to the ‘person who made the complaint’ rather than ‘complainant’ in our work. At times we use words and terms directly from the *Mental Health Act 2014* (Vic) (the Act) to ensure accuracy of meaning. However, when we know how a person wishes to be referred to, we respect this wherever possible.

The following are terms used by the MHCC in this report.

Advance statement: A document that sets out a person’s preferences for treatment in the event they become a compulsory patient under the Act.

Bodily restraint: A form of physical or mechanical restraint that prevents a person having free movement of his or her limbs but does not include the use of restrictive furniture such as beds with cot sides and chairs with tables fitted on their arms (s 3 of the Act).

Carer: A person, including a person under 18 years, who provides care to another person with whom they are in a care relationship, but not a parent if the person is under 16 (s 3 of the Act). Some people prefer terms such as ‘support person’, ‘family of choice’ or ‘partner’ to ‘carer’.

Care relationship: When a person receives care from or provides care to another person because one is older or has a disability, mental ‘illness’ or ongoing medical condition (as defined in the *Carers Recognition Act* 2012).

Complaint: An expression of dissatisfaction about a mental health service for which a response or resolution is explicitly or implicitly expected from the MHCC or is legally required (based on Australian Standard AS/NZS 10002:2014). Complaints to the MHCC can be made orally or in writing. To be formally accepted, they need to be made or confirmed in writing.

Consumer: A person who accesses mental health services (see s 3 of the Act). People with lived experience of accessing mental health services also describe themselves as ‘service users’, ‘survivors’, ‘clients’ and ‘patients’.

Enquiry: A request for information, advice or assistance. Enquiries to the MHCC can include requests from people for information about accessing services or on how to make a complaint about their treatment or care.

Mental health services: Designated mental health services and publicly funded mental health community support services (see s 3 of the Act):

- designated mental health services: public mental health clinical services prescribed under the Act that may compulsorily assess and treat people under the Act. These services also provide treatment on a voluntary basis and include hospital-based, community, residential, specialist and forensic services
- publicly funded mental health community support services: community support services for people experiencing mental health issues that are publicly funded and provided by non-government organisations.

Mental illness: The Act defines ‘mental illness’ as a medical condition that is characterised by a ‘significant disturbance of thought, mood, perception or memory’ (s 4(1)) and the MHCC uses this term when legal accuracy is required. However, many people find this term unnecessarily pathologises their experience and distress. Many people prefer other terms including ‘mental ill-health’, ‘mental health condition’, ‘mental health challenges’ or mental health issues. The MHCC prefers to use these terms wherever possible.

Nominated person: Under the Act, the role of a nominated person is to:

- provide the patient with support and to help
 - represent the interests of the patient
 - receive information about the patient
- be consulted about the patient’s treatment
- assist the patient to exercise any right they have under the Act.

Recommendation: The MHCC has a function to identify, analyse and review quality, safety and other issues arising out of complaints against mental health services and to make recommendations for them to mental health service providers, the Chief Psychiatrist, the Secretary to the Department of Health and Human Services and the Minister for Mental Health in Victoria (s 228(j) of the Act).

Restrictive intervention: Seclusion or bodily restraint (s 3 of the Act).

Seclusion: The sole confinement of a person to a room or any other enclosed space from which they cannot leave (s 3 of the Act).

Undertaking: The MHCC can require a mental health service to make a formal undertaking to take specific action(s) in response to a complaint. Undertakings are used in many regulatory settings to promote compliance with laws and requirements without the need for court proceedings. They are legally enforceable in that the Commissioner can issue a compliance notice, with which it is an offence not to comply (s 243 and s 260 of the Act).

Appendix 2:

Education and engagement activities

01. Presentations

- Equally Well National Symposium
- Grampians Mental Health Conference
- Office of the Chief Psychiatrist Victoria (OCP) Advanced Statements and Nominated Persons Forum
- OCP Sexual Safety Forum
- Office of the Public Advocate Victoria (OPA) Community Visitors’ Training Day
- Safer Care Victorian Mental Health Clinical Network Strategic Planning Forum
- Tandem Carer Awards Event
- The Mental Health Services (TheMHS) National Conference (2 presentations)
- Towards Eliminating Restrictive Practices (TERP) 12th National Forum (2 presentations)
- VMIAC Consumer Consultant Forum
- Western Victorian Mental Health Learning and Development Cluster Program
- Women in Public Leadership Summit
- Women’s Mental Health Network Victoria 30th Anniversary Event

02. Education & training sessions

- AMES Disability Actions Group
- Fair Work Commission (Victoria) staff about the MHCC and mental health complaints
- Independent Mental Health Advocacy Victoria (IMHA) – new starter information sessions
- Mind Australia carer forum about the MHCC and carer complaints
- Monash Health Youth Stream Clinicians Education session

Information stands

- Department of Health and Human Services (DHHS) Mental Health Week Expo
- Eastern Metropolitan Region Orientation – Sector Overview
- Mental Health Victoria National Disability Insurance Scheme (NDIS) Conference
- Monash Health Expo at Dandenong Hospital

Projects

- Easy English guide to complaints – included consumer user testing and development by Scope Australia

03. Service visits and meetings about complaints data and themes

- Ballarat Health
- Bendigo Health
- Eastern Health
- Forensicare
- Mind Australia
- Monash Health
- North Western Mental Health (NWMH)

04. Consumer and carer engagement activities

- Action on Disability within Ethnic Communities
- ArtAbility awards
- Borderline Personality Disorder (BPD) community meeting
- Inner West Area Mental Health Service Consumer Advisory Group meeting
- Individual meetings with consumer consultants and peer workers
- Mental Health Tribunal Consumer and Carer forum
- Monash Health Mental Health Week Art Awards presentation
- Tandem carer awards judging panel, meetings and events
- VMIAC and Tandem Culturally and Linguistically Diverse (CALD) communities forum
- VMIAC consumer awards presentation, meetings and events
- Youth Advocate video interview of Commissioner on gender equality and the *Right to be safe* report

05. Contributions to consultations and projects

- Contributions included:
 - Australian Commission on Safety and Quality in Health Care (ACSQHC) – development of certification framework for the Digital Mental Health Services Standards
 - Australian Human Rights Commission & Victorian Equal Opportunity and Human Rights Commission Roundtable consultation on the implementation of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)
 - Australian Mental Health Outcomes and Classification Network (AMHOCN) – National Mental Health and Suicide Prevention Information Priorities
 - Better Care Victoria Innovation Fund – Innovation grants for Mental Health Services
 - Commonwealth Ombudsman – consultation on ‘National Preventative Mechanisms’ for the implementation of OPCAT in States and Territories
 - Department of Justice and Community Safety Victoria (DJCS) – Victorian Charter of Human Rights and Responsibilities (Registered National Disability Insurance Scheme (NDIS) Providers) Regulations
 - DJCS – Coroners Regulations under section 117 of the *Coroners Act 2008* (Vic)
 - Department of Health and Human Services Victoria (DHHS) – Client Voice Framework for Community Services
 - DHHS – Community Services Quality and System Architecture Project
 - DHHS – *Mental Health Lived Experience Engagement Framework*
 - DHHS – Victoria’s 10-year *Mental Health Plan* as part of the Progress Measures Working Group

DHHS – consultation on planned review of the *Mental Health Act 2014* (Vic)

DHHS – proposed legislative amendments for information sharing to implement *Targeting Zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*

DHHS – proposed amendments to *Mental Health Act 2014* (Vic) regarding NDIS and information sharing with the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission

DHHS – Disability Worker Registration Scheme

DHHS – Family Violence Primary Prevention Strategy Survey

Latrobe Health Advocate (Victoria) – consultation on strategic priorities relating to mental health

NDIS Quality and Safeguards Commission – consultation on complaints about NDIS services for people with psychosocial disabilities

South Australia Chief Psychiatrist – request for consultation on approaches to mental health complaints and *The right to be safe* report

South West Health Care – Mental Health Model of Care Review

SANE Australia – National Stigma Report Card Project

University of Melbourne – Adverse Events Reporting Framework Project for the Office of Chief Mental Health Nurse

Victorian Agency for Health Information (VAHI) – consultations on VHIMS Minimum Data Set and Mental Health Inspire report

Victorian Auditor General’s Office (VAGO) – consultation on the audit on ‘Access to Mental Health Services’

Victoria Police – Family Violence Report

VMIAC – consultation strategic directions

Victorian Royal Commission into Mental Health – Executive Roundtable on Terms of Reference

06. Submissions and formal feedback

Coronial Council – review of reportable deaths in Victoria

National Safety and Quality Health Service (NSQHS) – user guide for health services providing care for people with mental health

Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health

Royal Commission into Victoria’s Mental Health System – Terms of Reference

Royal Commission into violence, abuse, neglect and exploitation of people with disability – Terms of Reference

07. Participation in advisory and reference groups

DHHS Progress Measures Working Group

DHHS Lived Experience Advisory Group (Associate member)

Office of the Chief Psychiatrist (OCP) Human Rights Project Advisory Group

OCP Sexual Safety Committee

OCP ‘Working together with Families and Carers’ Implementation Working Group

Victorian Ombudsman OPCAT Investigation Advisory Group

Safer Care Victoria Mental Health Clinical Network Insight Subcommittee

08. Other stakeholder meetings and events

Meetings (involving liaison and consultation)

Australia and New Zealand Health Complaints and Disability Commissioners meetings

Australia and New Zealand Mental Health Commissioner meetings

Australian College of Mental Health Nurses (ACMHN) – consultation regarding *The right to be safe* report findings and recommendations

Australian Health Practitioner Regulation Agency (AHPRA) liaison and consultation meetings

Commissioner for Senior Victorians liaison and consultation meetings

DHHS liaison and consultation meetings

Disability Services Commissioner (DSC) liaison and consultation meetings

Health Regulatory Intelligence Sharing Committee

Independent Mental Health Advocacy liaison and consultation meetings

Mental Health Tribunal liaison and consultation meetings

National Disability Insurance Agency (NDIA) Strategic Adviser (Mental Health)

NDIS Quality and Safeguards Commission – meetings regarding NDIS transitional arrangements

National Health Practitioner Ombudsman & Privacy Commissioner – consultation meeting

National Mental Health Commission liaison and consultation meetings

Office of Chief Psychiatrist (OCP) liaison and consultation meetings

Office of Public Advocate (OPA) liaison and consultation meetings

Premier’s Volunteer Champion Awards program and judging panel

Safer Care Victoria liaison and consultation meetings

Victorian Aboriginal Community Controlled Health Organisation (VACCHO) Inc

Victorian Agency for Health Information (VAHI) liaison and consultation meetings

Victorian Equal Opportunity and Human Rights Commission (VEOHRC) Commissioners Strategic Group meetings

Sector Events

Australasian College for Emergency Medicine (ACEM) Mental Health Summit

Australian Health Practitioner Regulation Agency (AHPRA) National Registration and Accreditation Scheme research summit

Dax Centre STIGMA exhibition – Dismantled, Revealed, opening and launch event

Intersex Health and Wellbeing Resource launch – Commissioner for Gender and Sexuality

Institute of Public Administration Australia (IPAA) Oration by Victorian Treaty Advancement Commissioner

IPAA Leadership in the Public Sector Awards

IPAA National Conference: Fault lines for the future of the public sector

Mental Health Victoria – CEO Breakfast and stakeholder events

Midsumma – 24th Pride March

NAIDOC week activities

National Investigations Symposium for statutory and regulatory bodies

NDIS and Mental Health Conference – Mental Health Victoria

Office of the Public Advocate and RMIT Future Social Services Institute forum on NDIS and safeguarding people’s rights

Office of the Public Advocate and RMIT Future Social Services Institute forum on the justice system and people with disabilities – ‘Disabling Justice’.

Premier’s Volunteer Champions Award Ceremony

Rotary International Women’s Day event on human rights

TheMHS (Australia and New Zealand) Summer Forum: Community Mental Health Systems: Human Rights and Services – Special Rapporteur for event

University of Melbourne Social Equity Institute and Forensicare event – *Policing and Mental Health*

Victorian Agency for Health Information Annual Forum 2018

Victorian Public Healthcare Awards 2018

Victorian Public Service (VPS) Pride Awards

Appendix 3:

Operations

Financial statement for the year ended 30 June 2019

The Department of Health and Human Services (DHHS) provides financial services to the Mental Health Complaints Commissioner (MHCC).

The financial operations of the MHCC are consolidated into those of DHHS and are audited as part of the DHHS accounts by the Victorian Auditor-General’s Office. A complete financial report is therefore not provided in this annual report.

A financial summary of expenditure for 2018–19 according to DHHS accounts is provided below.

Operating statement for the year ended 30 June 2019	
Expenses	
Salaries and on-costs	\$2,387,149
Contractors/external services	\$278,773
Supplies and consumables	\$405,508
Total expenses	\$3,071,430

Appendix 4:

Compliance and accountability

Privacy and Data Protection Act 2014 and Health Records Act 2001

The Mental Health Complaints Commissioner (MHCC) is subject to the *Privacy and Data Protection Act 2014* in relation to the collection and handling of ‘personal information’ about individuals. ‘Personal information’ is recorded information that can identify a living person.

The MHCC must also comply with the *Health Records Act 2001* when dealing with ‘health information’. This is information that can identify a person, including a person who has died, about the person’s physical, mental or psychological health, disability or genetic make-up.

The MHCC’s privacy policy explains how we deal with personal and health information and is available on the MHCC’s website at www.mhcc.vic.gov.au/about-the-mhcc/privacy.

Freedom of Information Act 1982

In 2017–18 the MHCC made three decisions relating to freedom of information applications.

Requests for access to documents held by the MHCC, or the correction of documents held by the MHCC, can be made under the *Freedom of Information Act 1982*.

Applications can be made in writing to the MHCC at Level 26, 570 Bourke Street, Melbourne VIC 3000 or by email to PrivacyFOI@mhcc.vic.gov.au.

Charter of Human Rights and Responsibilities Act 2006

The *Charter of Human Rights and Responsibilities Act 2006* sets out 20 fundamental human rights for all people in Victoria, including the right to be treated equally and to have our privacy respected.

The MHCC is a public authority under the Charter and is required to act compatibly with the human rights in the Charter and to give proper consideration to Charter rights in dealing with enquiries and complaints.

Protected Disclosure Act 2012

Disclosures of improper conduct by the MHCC or its officers can be made verbally or in writing to:

Independent Broad-based Anti-corruption Commission
GPO Box 24234
Melbourne VIC 3000
Phone: 1300 735 135
Fax: (03) 8635 6444
Email: submit@ibac.vic.gov.au

More information about the *Protected Disclosure Act 2012* is available from the Independent Broad-based Anti-corruption Commission website at www.ibac.vic.gov.au.

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www.mhcc.vic.gov.au

Speak up.
Your experience
matters.

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

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