About the MHCC

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.

A rights-based approach to complaints

The MHCC's rights-based approach to resolving complaints means we:

- support people who contact us to understand and exercise their rights under the Act and through our complaints processes
- assess all complaints against the requirements of the Act and its principles, the Victorian *Charter of Human Rights and Responsibilities Act 2006* and other relevant standards and guidelines.

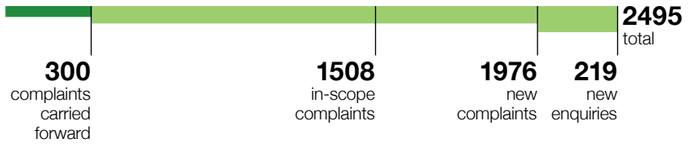
Our functions under the Act also include:

- **formally investigating** matters involving risk and safeguarding concerns identified in complaints
- **making recommendations** for service and system improvements to the Chief Psychiatrist, Secretary of the Department of Health and Human Services and the Minister for Mental Health in Victoria
- **seeking undertakings** from services to take specific actions in response to complaints, which are legally enforceable
- **overseeing local complaints reporting** by all Victorian public mental health services. Services must provide the MHCC with twice-yearly data detailing the number and outcomes of complaints made to them
- **undertaking strategic projects** arising from complaints, sharing lessons learnt to ensure rights are protected and there is broader system improvement
- **educating and engaging** people and services about what is involved in making and managing complaints.

The MHCC Advisory Council is made up of eleven diverse people who have lived experience as consumers, family members and carers or who work in mental health services. Members provide strategic advice and collaborate with us to ensure our work is informed and driven by lived experience.

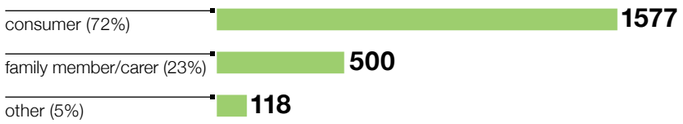
Overview of complaints

Enquiries and complaints to the MHCC in 2018–19
In 2018-19, we dealt with more enquiries and complaints than ever before.



The number of 'out-of-scope' complaints reflects the impact of the Royal Commission into Victoria's Mental Health System, with people raising concerns about the broader mental health system or older concerns, which the MHCC is unable to deal with.

Who made enquiries and complaints to the MHCC? (*n* = 2195)



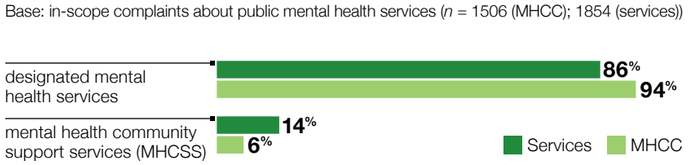
Complaints made to services in 2018–19

The Act requires mental health services to provide us with twice-yearly data including the number and outcomes of complaints they receive. We analyse this data and compare it with complaints to the MHCC. This allows us to identify quality and safety issues across the sector, informing our strategic projects and recommendations for service improvement.

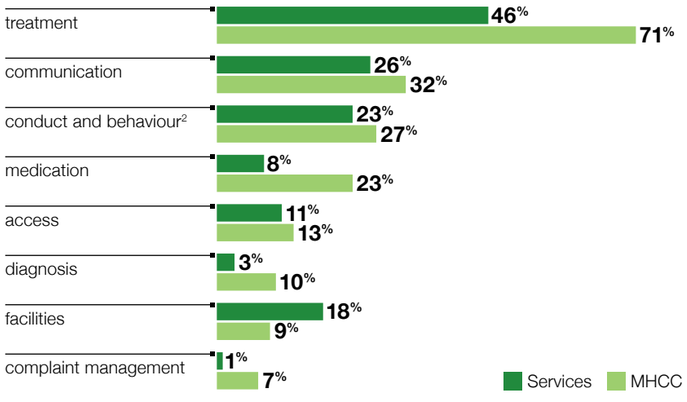
In 2018-19 all public mental health services provided reports of complaints made directly to services, reporting 1,854 in-scope complaints[1].

The types of complaints made to services compared to complaints made to the MHCC are shown in the figures below:

What type of services did people make complaints about?
Base: in-scope complaints about public mental health services (*n* = 1506 (MHCC); 1854 (services))



What issues did people make complaints about?
Complaints raised with the MHCC and services often involve more than one issue. The figure below compares the percentage of all complaints to the MHCC and services that raised at least one issue relating to the following categories.



1 Complaints that were made via the MHCC were excluded from this data to avoid duplication.
2 Includes rudeness and lack of empathy.

- **Complaints about treatment** mostly related to disagreement with treatment orders and inadequate treatment options or planning.
- **Complaints about communication** mostly related to the provision of inadequate, incomplete or misleading information, or inadequate communication with families and/or carers.
- **Complaints about conduct and behaviour** were most commonly about staff manner, including perceived rudeness, or a lack of respect or empathy. There were also smaller, but very concerning, proportions of complaints about alleged threats, bullying, harassment, assault, discrimination or sexual safety violations by staff or other consumers.

Complaints about facilities were much more likely to be raised directly with services than to the MHCC. Complaints about treatment, communication, conduct and behaviour and medication, which are generally more complex, were more likely to be raised with the MHCC than services.

The difference in the frequency with which treatment and medication complaints are raised with the MHCC compared to services is concerning, as it is expected that people would be encouraged and supported to raise treatment concerns with their treating team. We continue to work with services to ensure they uphold the mental health principles, including supporting people to make decisions about their assessment, treatment and recovery.

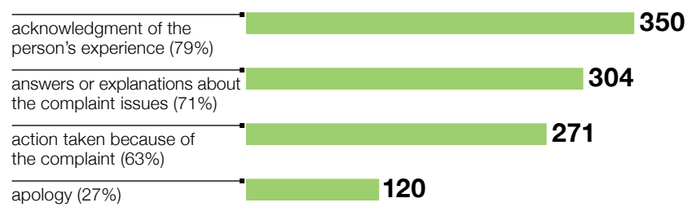
Outcomes of complaints to the MHCC

In 2018-19, the MHCC closed 1,897 complaints of which 1,437 were in-scope for our assessment and resolution processes[3].

Of the 1437 in-scope complaints, 427 were closed after detailed assessment and resolution processes and a further 484 people received support to raise their concerns with the service.

The remainder were closed after we assessed that resolution was not possible for reasons including insufficient details, lack of consent to proceed with the complaint, or the issues being more appropriately dealt with by another body. In these cases people received support, advice and referrals.

The 4 As: actions taken in complaints closed by the MHCC after detailed assessment and resolution processes (*n* = 427)



In 2018-19, we recorded 167 actions to improve services including:

- 77 recommendations to mental health service providers, the Chief Psychiatrist or the Department of Health and Human Services
- 88 service improvements arising from 37 complaints and investigations
- two formal undertakings from services to take specific actions in response to complaints, with three more currently being negotiated.

3 A further 369 complaints were still open at 30 June 2019 in various stages of assessment and resolution.

Example complaint:

Alex and Nerida

What Alex and Nerida told us

Alex drove himself to hospital to seek help for thoughts about self-harm and suicide. He was told by a staff member that he could either drive himself to a different part of the service to be assessed or come inside and 'wait your turn at the emergency department like everyone else'. Alex said he had taken medication and was unsafe to drive, but the staff member told him he seemed 'fine'.

Alex then called his mother, Nerida, who tried to explain that Alex was severely distressed and had a history of attempted suicide, but she did not feel listened to. Feeling that he hadn't been heard, Alex left the hospital and had an accident, sustaining a serious injury. Alex and Nerida told us that they hadn't been informed that the emergency department had been making plans to provide care and treatment to Alex while these discussions were occurring.

Nerida made a complaint to the hospital about the staff member's lack of communication, empathy and compassion, but was unhappy with the response and contacted the MHCC.

How the mental health principles applied to the complaint

Under the *Mental Health Act 2014* and its principles, Alex had the right to expect he would be supported to make or participate in decisions about his assessment, treatment and recovery and have his views and preferences respected. He told the staff member he was suicidal and not safe to wait or drive, but felt this was not acknowledged, and he was not told about plans for his treatment.

Nerida, as his mother and carer, had the right to have her role recognised, respected and supported and to be involved in decisions about Alex's assessment, treatment and recovery whenever possible. However, she felt she was unheard by hospital staff.

Our involvement

Nerida's complaint, which Alex consented to, raised serious questions about the hospital's apparent failure to provide compassionate and responsive mental health services to Alex when he asked for help. We assessed that the consequences of their experience could have been even more serious and requested that the service provide a written response to the complaint, which was followed by a facilitated meeting with Alex and Nerida.

In the meeting, Alex and Nerida explained how their experiences had impacted them and the service representatives apologised. The service also outlined several improvements they were making in response to the complaint, including moving the short-term treatment team closer to the emergency department; creating a quiet room in the emergency department for staff to talk to consumers, and providing training for all staff on being more responsive to consumer and carer views as well as individual training for the staff member involved.

Outcomes

After the meeting, Alex and Nerida told us that the hospital's acknowledgment, apology and actions regarding their experiences had addressed and resolved their concerns. We closed the complaint on this basis and because we assessed that the service was taking appropriate steps to prevent a recurrence of the issues raised. We have also highlighted the broader systemic issues of people with suicidal thoughts not receiving compassionate, appropriate mental health care at emergency departments in our submissions and consultations for the Royal Commission into Mental Health and the Productivity Commission's mental health inquiry.

Working for change

As well as our complaints work, the MHCC works collaboratively to safeguard peoples' rights and improve Victoria's public mental health system through service and system development and education and engagement.

Service and system contributions

32 contributions to sector consultations, projects, submissions, including to the Royal Commission into Victoria's Mental Health System

7 memberships of advisory and reference groups

22 sector events attended

51 additional stakeholder meetings and events attended

Education and engagement

In 2018-19 we focussed on working with our Advisory Council; presenting to larger audiences; targeting education activities on complaint themes and effective approaches to resolving complaints; increasing our regular meetings with mental health services; and further integrating our education and engagement and complaints resolution activities.

2542 people reached

83 presentations, training sessions and other activities

6991 information products distributed

4881 social media followers

38 440 views of our website

Please see the MHCC's full annual report for more information about our work via: www.mhcc.vic.gov.au/resources/publications.

Speaking up improves services for you and for other people

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

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www.mhcc.vic.gov.au

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Annual Report Summary 2019

MHCC MENTAL HEALTH COMPLAINTS COMMISSIONER