Mental Health Complaints Commissioner

Annual Report 2020

MHCC MENTAL HEALTH COMPLAINTS COMMISSIONER

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Commissioner's message

This year has seen an unprecedented focus on mental health in our community, with the impacts of the bushfires, the significant and unique challenges of the COVID-19 pandemic and the landmark work being undertaken by the Royal Commission into Victoria's Mental Health System and the Productivity Commission's Mental Health Inquiry. It has been a year in which we have witnessed heightened need and levels of distress in people seeking assistance from mental health services and the Mental Health Complaints Commissioner (MHCC). However, at the same time we have seen mental health increasingly recognised as a priority concern across our community, with significant commitments by governments and a collective sense of hope and support for the proposed reforms for the mental health system.

Contributing to reforms

More than ever, this year has shown the value of the MHCC's role as an independent, specialist complaints body that provides an accessible and supportive avenue for addressing people's individual concerns and uses the insights from their complaints to drive improved service responses and broader system reform. Our submissions to the Royal Commission into Victoria's Mental Health System and the Productivity Commission's Mental Health Inquiry highlighted the critical issues of rights, safety and quality identified in complaints to the MHCC since it was established in 2014. Key insights and data from the MHCC's work were referenced in the interim reports of both Commissions, which then sought further contributions from us to inform their considerations and final recommendations. We have welcomed the opportunity to provide a window into thousands of people's experiences of mental health services through sharing the data and insights gained from complaints made directly to the MHCC as well as those reported by services.

Our contributions to the Royal Commission over the past year have continued to draw attention to incidents of avoidable harms and trauma identified in complaints to the MHCC, and actions required to ensure the safety and uphold the rights of people accessing mental health treatment. We also continued to highlight the importance of the MHCC's safeguarding and oversight role, and the need for rights-based, recovery-oriented and trauma-informed practices to be truly embedded in service provision and driven by the lived experience of consumers, families and carers.

Responding to COVID-19 impacts

The value of the MHCC's unique role as a specialist mental health complaints body was also highlighted in our capacity to provide supportive and agile responses to the impacts of the COVID-19 crisis. Since the outset of the pandemic we have responded to increasing levels of distress expressed by callers seeking assistance from the MHCC, as well as complaints about the direct impacts of COVID-19 on mental health service provision. Through these calls and complaints, we have been able to identify themes and experiences of mental health consumers, families and carers during the COVID-19 crisis, as they emerge. These have been shared in regular meetings with the Victorian Department of Health and Human Services (the DHHS), and with other mental health commissioners, to progressively inform mental health responses at both a state and national level. The insights gained from dealing with complaints during this period informed the Victorian Government's COVID-19 mental health response, the *National Mental Health and Wellbeing Pandemic Plan* and were shared internationally in a webinar on the 'Global impact of COVID-19 on Mental Health' hosted by the Australian National University.

The COVID-19 pandemic has made us all remember the importance of compassion and kindness in our lives and work, and the value of sharing ways of responding to the challenges together. It has also highlighted the importance of reaching out to those who may be particularly vulnerable due to increased isolation, uncertainty and stress.

During this crisis, we have seen services and organisations in the sector coming together with the DHHS to share insights and practices and to collaborate on shared approaches. The crisis has also shown us new ways of working and delivering services, such as through increased use of technology. Like other organisations, we had to adapt quickly to new ways of working to maintain our phone line and engagement with consumers, families, carers, services and other stakeholders through use of video and other digital technologies. Noting the challenges and pressures on mental health services, we appreciated their willingness to work flexibly with us in responding and resolving concerns raised by consumers, families and carers during this period. In recognition of the COVID-19 impacts on services, we suspended the local complaint reporting requirements for the January–June 2020 period and extended timeframes for responses to investigations and undertakings. We were, however, still able to progress resolution of complaints through a range of flexible approaches, including the use of teleconferences and video for facilitated meetings, which we hope will further increase the accessibility of these processes in future.

Resolving complaints, safeguarding rights and driving improvements

The number of people seeking assistance from the MHCC has continued to increase every year. In 2019–20 we received 2,369 new enquiries and complaints, an increase of approximately eight per cent from 2018–19. Including 369 complaints carried forward from the previous year, we dealt with a total 2,738 enquiries and complaints in 2019–20, 1927 of which were in-scope complaints. The themes in complaint issues were consistent with previous years, apart from the new issues associated with COVID-19 impacts on services. These included managing risks of infection, changes to access and service delivery, restrictions on visitors and leave from inpatient units. The positive outcomes of complaints, and types of actions taken, were also similar to previous years, with 82 per cent of in-scope complaints being partially or substantially resolved. Many of these actions involved service improvement initiatives by services or recommendations by the MHCC to prevent similar incidents occurring.

Behind these figures, we must never lose sight of the difference that resolving a person's concerns can make to their individual recovery and willingness to engage with services in the future. We also need to recognise the challenges of finding a resolution when people are deeply aggrieved and distressed by their experiences. The feedback from an end-of-year survey of people, who have made complaints to the MHCC, reinforces the value of people feeling heard and respected and knowing that their complaint had resulted in positive changes. The feedback also highlights the need for the MHCC to keep addressing the volume and complexity of complaints, and the challenges of resolving complaints where the desired outcomes are outside the scope of the MHCC's powers or processes.

Over 2019–20 there were 272 service improvement actions recorded as outcomes of complaints, including 148 actions taken by services, 121 recommendations made by the MHCC to mental health services and three recommendations to the Secretary of the DHHS and the Chief Psychiatrist for systemic improvements. In addition, we sought and accepted four legal undertakings from services to undertake a range of service improvement and compliance actions. Over the past year, complaints about the use of mechanical restraint of mental health consumers in emergency departments have raised significant concerns. In a similar way to our work on sexual safety in acute inpatient units, including our *The Right to be Safe* project report, our detailed assessments and investigations of these complaints uncovered profound systemic failures and significant issues of human rights and avoidable harms. These have been highlighted in our recommendations to the Secretary of the DHHS and Chief Psychiatrist to address the systemic issues on the use of mechanical restraint, and in compliance actions required of services through the legal undertakings and our investigations. We have also highlighted the need for priority attention to these issues in our presentations and education activities with services and in our consultations with the Royal Commission and Safer Care Victoria.

Engaging, educating and contributing to the mental health sector

In 2019–20, as part of our education function, we also continued to engage with the mental health sector in a variety of ways to promote awareness of the role of the MHCC and effective approaches to complaints. We directly reached 4,648 people through targeted education and engagement activities, and at least 15,000 more through 'broad reach' activities such as our information stall at the Midsumma Carnival and my opening address at the Mental Health Week's Walk for Mental Health. Our activities continued to focus on ensuring that the MHCC is accessible, inclusive and safe for all Victorians. These included adopting Instagram to reach more young people, participating in LGBTIQ+ events and engaging with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). During the COVID-19 restrictions, we continued our engagement and education activities through digital platforms, including radio interviews and social media. We also published an analysis of three years of comparative complaints data from local complaint reports, a summary of responses by services to the sexual safety recommendations of *The Right to be Safe* report and contributed to 33 consultations, projects and advisory groups as part of our service and systemic improvement function. With the many activities undertaken, and challenges faced over the year, 2019–20 has certainly been a busy one for the MHCC.

Reflections and thanks

After six rewarding years as the inaugural Mental Health Complaints Commissioner, my term of office concluded on 30 June 2020. I wish to thank everyone who has supported the work of the MHCC since it was established. It has been a true honour and privilege to have led the work of the office and been entrusted with hearing the challenges and concerns people have experienced within the mental health system. During my time in the role I have been struck by both the gravity and the generosity of people's stories, and by what can be achieved when consumers, families, carers and services work together with a focus on rights, recovery and improving outcomes for all.

The MHCC has a unique role to play in contributing to the mental health reform agenda going forward. Complaints shine a vital light on what needs to change in order to improve people's experiences, and also whether changes and reforms are working. The reasons why the MHCC was established as an independent specialist mental health complaints body are as important now as they were six years ago. The MHCC has clearly demonstrated the value of its specialist role and also the need to further strengthen quality and safeguarding mechanisms in the proposed reforms of the mental health system.

I give special thanks to the MHCC staff for their unwavering passion and commitment to making a positive difference through the MHCC's work, and the values, care and skills they demonstrate in their work every day. I am particularly proud of how all staff worked together with the MHCC Advisory Council to co-produce the *Driven by Lived Experience* framework and strategy which articulates the way in which the MHCC's approaches are informed and driven by the lived experience of consumers, families and carers. I am also indebted to all members of the MHCC Leadership Group for their shared stewardship of the MHCC's work, and their tireless efforts in ensuring that staff were supported, connected and able to continue to perform the important work of the MHCC in the face of the COVID-19 crisis and other challenges throughout the year.

I also thank the members of the MHCC Advisory Council for their commitment and invaluable contributions throughout the year, particularly in the development of the *Driven by Lived Experience* framework and strategy. Each of the Council members contributed their unique insights, wisdom and experience as consumers, carers and people working within services. I give special thanks to Dr Anthony Stratford who generously contributed his lived experience, expertise, insights, knowledge and time over four years as the Council's inaugural Chair.

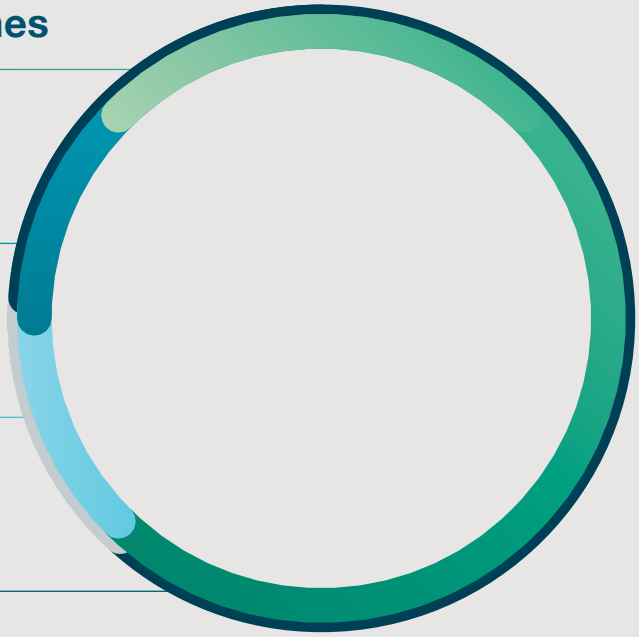
I thank the Hon Martin Foley, Minister for Mental Health for his support of the MHCC's role and acknowledge his strong commitment to addressing the mental health needs of our community and the impacts of the COVID-19 pandemic. I also acknowledge the support of the Secretary of the DHHS and departmental officers, the Chief Psychiatrist and Chief Mental Health Nurse and their staff, clinical and executive directors of services, the Victorian Mental Illness Awareness Council (VMIAC), Tandem and the many committed people in the sector and other statutory bodies, who have worked with the MHCC on our shared goals of safeguarding rights and improving people's experiences of mental health services.

From 1 July 2020, the work of the MHCC will be led by a Commissioner who will hold the dual roles of Disability Services Commissioner and Mental Health Complaints Commissioner. The MHCC's role as a separate independent statutory body and the scope of its work has not been changed. I want to offer my best wishes to Ms Treasure Jennings who has been appointed to this new dual Commissioner role and to all those who will contribute to the important work of the MHCC into the future.

Dr Lynne Coulson Barr OAM
Mental Health Complaints Commissioner
1 July 2014–30 June 2020

Year at a glance

Complaint numbers and outcomes

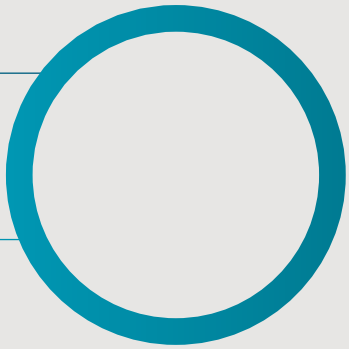


2 738
total enquiries and complaints dealt with

2 369
new enquiries and complaints

345
matters open on average at any one time

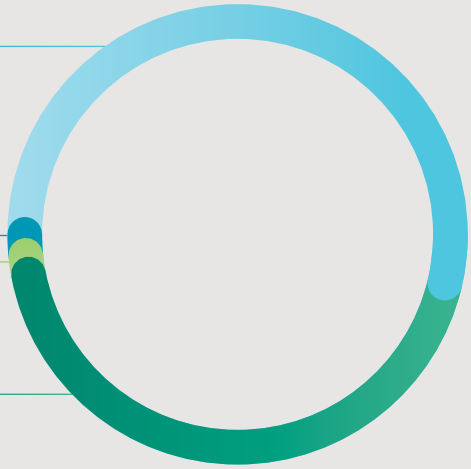
82%
of complaints had positive outcomes and actions for consumers, families and carers, either through being fully or partially resolved by the MHCC or through the MHCC assisting in direct resolution of complaints with services



767
in-scope complaints reported by public mental health services

100%
of services provided local complaints reports

276
Actions to improve services including:



148
service improvements as outcomes of complaints

3
systemic recommendations to the Chief Psychiatrist, Department of Health and Human Services or Safer Care Victoria

4
formal undertakings from services to take specific actions in response to complaints

121
recommendations to mental health service providers

Education and engagement activities

15 000+
people reached through broad reach activities, including consumers, families, carers, service staff and other stakeholders

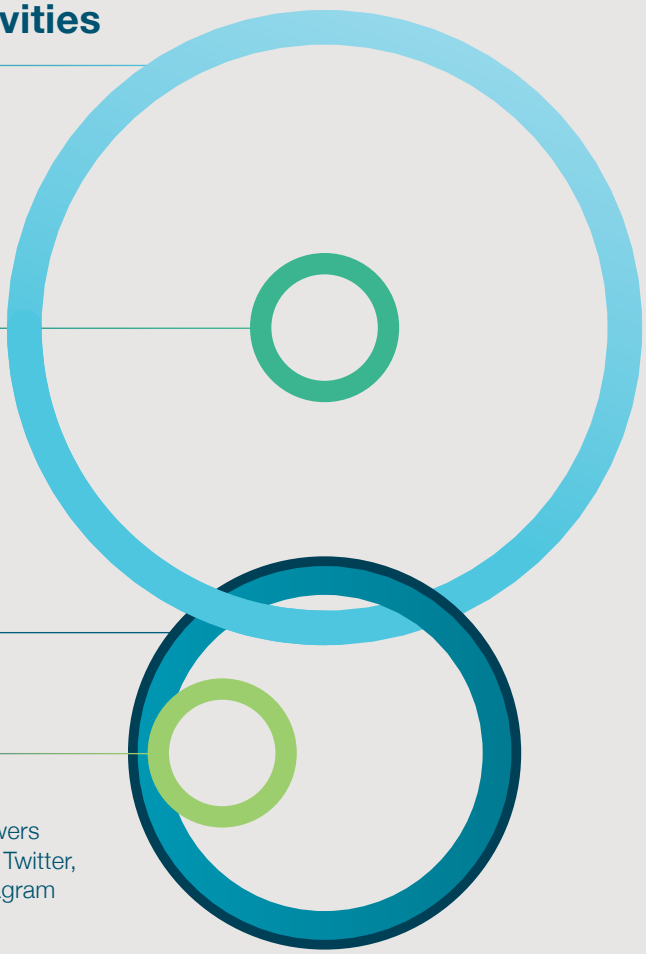
4 648
people reached through direct activities

34
direct education and engagement activities, including presentations, training sessions and other activities

48 691
web page views and

20 852
sessions

6 237
social media followers across Facebook, Twitter, LinkedIn and Instagram



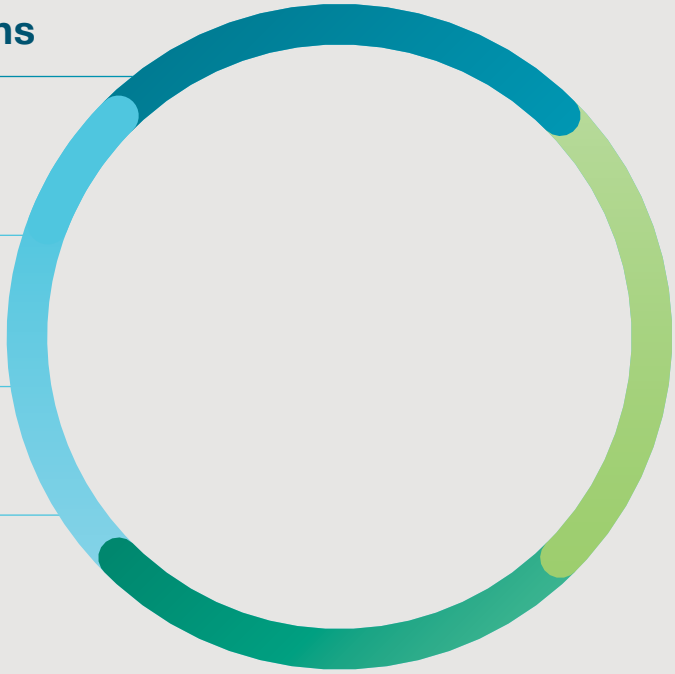
Service and system contributions

27
contributions to sector consultations, projects, submissions and formal feedback

6
memberships of advisory and reference groups

19
sector events attended

80
additional stakeholder meetings and events attended



About the MHCC

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 *Mental Health Act 2014* (Vic) in all aspects of service delivery.

The 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.

The Mental Health Complaints Commissioner (MHCC) can take complaints about issues including access, treatment and care that people have experienced in:

- **designated mental health services** including hospital-based, community, residential, specialist and forensic services
- **publicly funded mental health community support services** if they are *not* funded by the National Disability Insurance Scheme (NDIS)
- **NDIS services** if the complaint is about things that happened before 1 July 2019 or before the service was funded by the NDIS. Otherwise, responsibility lies with the NDIS Quality and Safeguards Commission.

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 Victorian 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 (page 18), the MHCC can make recommendations for service and system improvements and use our 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 and it is an offence for the service not to comply with this notice.

The MHCC also carries 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 learned 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. See 'Local complaints reporting' on page 44.

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.

The Mental Health Act 2014 (Vic) – our functions

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

- to accept, assess, manage and investigate complaints relating to public mental health services
- to endeavour to resolve complaints in a timely manner using formal and informal dispute resolution (including conciliation), as appropriate
- to provide advice on any matter relating to a complaint
- to make the procedure for making complaints in relation to services available and accessible, including publishing material about the complaints procedure
- to provide information, education and advice to services about their responsibilities in managing complaints
- 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
- to assist services in improving policies and procedures for resolving complaints
- to identify, analyse and review quality, safety and other issues arising from complaints and to provide information and make recommendations for improvements to services, the Chief Psychiatrist, the Secretary of the Department of Health and Human Services (the DHHS), the Minister for Mental Health and other agencies as listed
- to investigate and report on any matter relating to services at the request of the Minister.

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.

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.

Lived Experience and the Advisory Council

I know that my and others' lived experience is valued and it [the MHCC] is genuinely lived experience driven from the beginning to now.

— MHCC Advisory Council member

The MHCC is committed to being driven by the lived experience of consumers, carers and families in everything we do. We are informed by what people tell us through their complaints, which represent the lived experiences of thousands of people each year. People with a lived experience of mental health issues, as well as families and carers, hold uniquely valuable insights into how mental health services can best respond to people's needs and promote recovery. We know that working in partnership with consumers, carers and families is key to making meaningful improvements in the mental health system.

In addition, we encourage people with a lived experience to apply for roles in our office and engage regularly with lived experience organisations, workers and groups. As well as staff with lived experience, we have a dedicated role of Senior Advisor, Lived Experience and Education and our Deputy Commissioner is a lived experience leader – both have a key role in the MHCC's Leadership Group.

The MHCC's Advisory Council is another way we ensure we are driven by lived experience in the design, development and delivery of all our work. Further details are below.

From Maggie Toko

Deputy Commissioner and lived experience leader

Kia Ora everyone! I have been in my role of Deputy Commissioner since 29 January 2020. It has sent me on a huge learning curve and connected me to some of the most passionate workers I can recall ever working with. The myriad calls received by the Resolutions team enlighten them and us as managers into a world where consumers struggle to be recognised. Contact with the MHCC is the first time some consumers have been heard and listened to in their journey of recovery. There are many themes that run through the differing calls and I feel a commitment to highlight that data as much as possible.

During COVID-19 I have been communicating with the rest of the team on Microsoft Teams or via phone and email and, regardless of demand, they are always ready to undertake new tasks and new ways of doing things. We are confronted now every day with a new world order. It is a time of reflection for everyone, and those of us with lived experience are that much more susceptible to unauthorised thoughts. I speak of this as someone who is generally well, except for the slight fact that I suffer paranoia. I have found that at this time more than ever I need to stay well and healthy. I need to speak up when necessary and be frank when I can, thereby delaying any opportunity for paranoia to take over. It is how I work with my recovery which I accept will always be an ongoing journey.

In the unprecedented times that we are experiencing, everyone's mental health is being questioned. People are suffering self-doubt, unwanted thoughts and fears – that has become our normal. Now more than ever we need to hang on to hope as our way through this pandemic. We will get through this though, slightly worse for wear but in one piece. I plan to transition back into the office when all this is over, forge respectful relations in person and cherish the fact that I have survived.

The MHCC prides itself on being inclusive and engaged in the experiences of those with lived experience. As Deputy Commissioner I feel a responsibility to champion the rights of consumers, carers and family members, ensuring that they have an opportunity to be heard. The MHCC is currently working on a lived experience framework and strategy which provides direction for the office into the future. The MHCC prioritises safety in the workplace and continually supports lived experience staff.

From Emma Bohmer

Senior Advisor, Lived Experience and Education

Lived experience advisory roles involve using your personal experiences of mental and emotional distress as well as the journey of navigating the mental health system to bring about systemic change. The voices of those with lived experience are powerfully impactful and are beneficial for all as consumers, families and carers offer unique insights and identify valuable opportunities to make improvements that would otherwise remain unknown.

— Emma Bohmer

Emma Bohmer, our Senior Adviser, Lived Experience and Education, joined the MHCC in June 2019, on secondment from her role as consumer consultant for St Vincent's Hospital. She is the lead for our *Driven by Lived Experience* project, which has produced a foundational framework and strategy for how the MHCC is informed and driven by lived experience in all of our work. She also contributes her lived experience perspective to our Leadership Group, education and engagement activities, practice guidance, complex complaints, investigations and provides secretariat and other support to our Advisory Council.

The Advisory Council

The Advisory Council has worked very hard again this year respecting the three representative areas involved. Namely lived experience of mental ill-health and recovery, carer and family representatives and those representing services. It is a Council who understands the importance of co-production and works towards achieving this at each meeting.

— Dr Anthony Stratford, Inaugural Chair, MHCC Advisory Council

Our Advisory Council is the primary way the MHCC draws upon the insights, voices and guidance of diverse people with lived experience of mental health issues. The Advisory Council is composed of people of various ages, cultural and linguistic backgrounds and gender and sexual identities who have lived experience as consumers, family members, support people or carers, or who work in mental health services. They draw on their unique personal and professional expertise to:

– advise and guide us on our approaches to our work

– facilitate input from consumers, families, carers and service providers

– be involved in specific practice improvement and strategic projects

– participate in our recruitment processes.

The MHCC's Advisory Council also has six Associate Members who contribute to MHCC working groups and specific projects and undertake other tasks requested by the Advisory Council so that the MHCC can be informed by a broader range of experiences and perspectives.

In 2019–20 Advisory Council activities have included:

– working with the MHCC's Lived Experience project team to develop a framework for how the lived experience of consumers and carers informs and drives our work

– a presentation by Elvis Martin, Advisory Council member and Ambassador for RUOK? Day, at the event hosted jointly by the MHCC and the Disability Services Commissioner on RUOK? Day

– a targeted consultation to inform the Productivity Commission's *Inquiry into the Social and Economic Benefits of Investing in Mental Health* in conjunction with the Mental Health Tribunal and Independent Mental Health Advocacy

– input into the MHCC's submissions to the Productivity Commission's Mental Health Inquiry and Royal Commission into Victoria's Mental Health System

– engaging with the LGBTIQ+ community via the MHCC's information stall at the Midsumma Carnival and participating with staff in the 25th Midsumma Pride March

– starting a series of papers that highlight common mental health complaint issues, the *Mental Health Act 2014* (the Act) and its principles, consumer and carer rights and mental health service responsibilities

– updating the MHCC's social media policy and helping implement its Instagram social media platform

– working with us to create MHCC acknowledgements of Aboriginal and Torres Strait Islander people and people with lived experience

– contributing to the direction, design and content of this annual report.

Advisory Council Members

Both the Commissioner and the staff made all Advisory Council members feel valued and in a warm, engaging and respectful manner. [It's] such an inspiring, respectful and collaborative environment.

— MHCC Advisory Council member

All members of the MHCC's Advisory Council were invited to extend their appointments beyond August 2020 until 31 December 2020 to ensure continuity of operations, particularly in light of the impacts of the COVID-19 pandemic.

Members of the Advisory Council who served during 2019–20 are:

Chair Dr Anthony Stratford, who resigned from this role in June 2020, played an integral role as the inaugural Chair in establishing the Advisory Council and brought deep insights from his lived experience along with broad national and international experience in recovery-oriented practice, research, training and peer-led initiatives. Dr Stratford is driven to see recovery-oriented practice embedded into all aspects of mental health treatment and care.

Robyn Callaghan has seen and experienced some disturbing environments and behaviour in mental health services. She uses her lived experience as a consumer and in peer-led recovery to work with others committed to upholding human rights and dignity and contributing to recommendations which will help reform mental health services and systems to be more humane, less discriminatory and wiser in practice.

Katrina Clarke has worked as a Senior Family/Carer Consultant since 2007 and is passionate about lived experience engagement and progression of the mental health workforce. She remains abreast of current advocacy issues through her membership of many national, state, local and regional groups. Katrina is a Community Member for the Mental Health Tribunal, on the Executive of the National Mental Health Consumer and Carer Forum and the Board of Tandem, and supports the Carer Lived Experience Workforce in Victoria.

Dean Duncan is the Executive Director of Education for VACCHO and a proud Kamilaroi man who was awarded NAIDOC's National Person of the Year in 2019. He has dedicated his life to creating positive change for Aboriginal and Torres Strait Islander people and will help ensure the MHCC is culturally responsive and accessible.

Hanna Jewell brings extensive experience in clinical mental health services, workforce training and family-inclusive practice to the Advisory Council. She aims to help clinicians, consumers, families and service staff improve service responses for people experiencing mental ill-health and their families.

Dr Michelle Knuckey has worked in the public mental health system for 18 years, mainly in the Child and Adolescent sector as a psychiatrist. She would like to support change in services directed by the experience of consumers and their families and is passionate about ensuring services listen and hear these voices.

Elvis Martin, our youth member, is an Ambassador for RUOK? Day and the National Youth Commission Australia as well as Chair of the National Youth Advisory Committee of the Red Cross. The focus of his leadership and advocacy work is on young people and mental health, homelessness, family violence, suicide prevention and LGBTIQ+ issues. He uses his platform, including a large social media following, to promote inclusion, diversity and equality for all.

Annette Mercuri, a Carer Consultant, has seen the negative impact that excluding family and carers from treatment and support can have on families and recovery through two generations of mental ill-health in her family. She is a strong advocate for working in partnership with consumers, clinicians and family/carers to create better outcomes for all.

Debbie Prout is a Senior Mental Health Nurse who has worked in adult, child and adolescent clinical and leadership positions in public mental health services since 1997. Debbie is keen to ensure consumer voices are heard and that people pay attention to their insights on how public mental health services can be improved. She finished her term of appointment on the Advisory Council in June 2020 due to other commitments.

Gloria Sleaby has worked in complaints resolution and has family members with lived experience of mental ill-health. Currently a finance professional in the healthcare industry, she is motivated to contribute advice that influences positive change for consumers and carers.

Tom Wood draws on his lived experience of mental health issues and as a consumer to advocate for high quality, accessible, respectful and innovative mental health services. He is a project peer worker at Peninsula Health Mental Health and on the Committee of Management of VMIAC. Tom believes lived experience voices are integral to effective reform in mental health.

Being in this Advisory Council has been my best experience of advisory councils/groups.

— MHCC Advisory Council member

Thoroughly enjoying my input and being listened to.

— MHCC Advisory Council member

Very welcoming and warm group, very inclusive leadership.

— MHCC Advisory Council member

There is genuine collaboration and power differentials are minimal. Feel very safe in the group.

— MHCC Advisory Council member

It is a privilege to be part of the MHCC's Advisory Council, which advocates strongly and is driven by the person's lived experience.

— MHCC Advisory Council member

Driven by Lived Experience project

The MHCC has had a clear commitment to the experiences and voices of people with a lived experience.

— MHCC Advisory Council member

The MHCC started its *Driven by Lived Experience* project in 2018. The aim of the project was to articulate and further develop approaches to ensure all aspects of the MHCC's work are informed and driven by lived experience. The result is the *Driven by Lived Experience framework and strategy* informed by the key principles of co-production. These principles include partnering with consumers from the outset; acknowledging, exploring and addressing power differentials; and developing consumer leadership and capacity.

The *Driven by Lived Experience framework and strategy* documents:

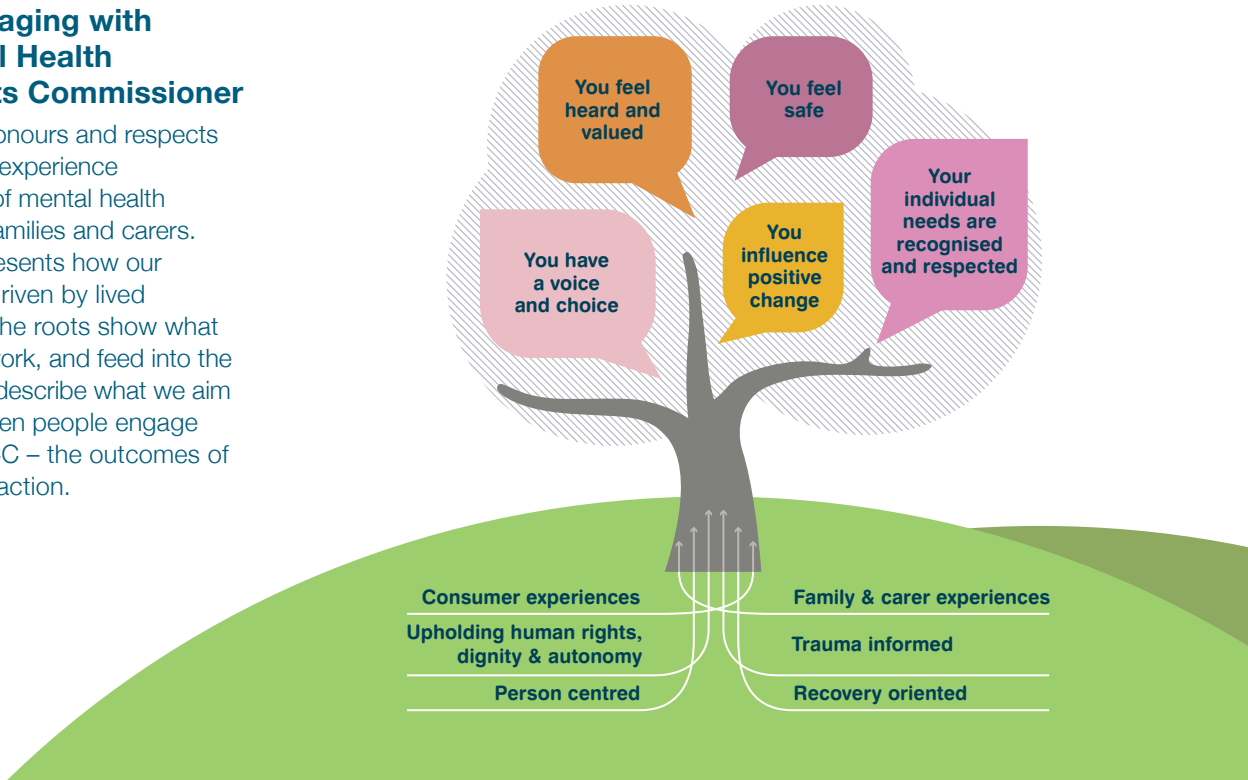
1. the history of how the MHCC was informed by lived experience during its establishment and early years
2. the new Driven by Lived Experience principle to complement the MHCC's five existing principles:

   We are driven by the voice and collective experience and wisdom of consumers, families and carers. We honour and respect lived experience in all our work.
3. what the Driven by Lived Experience principle means in practice, with a Lived Experience Tree (below) that visually represents the experiences we would like people to have when they engage with the MHCC
4. an accompanying set of statements showing the actions we are taking to achieve this
5. the MHCC Advisory Council's experience of the Driven by Lived Experience principle
6. a three-year strategy to progress the MHCC's lived experience work, informed by a detailed gap analysis and consultations with MHCC staff teams and Advisory Council.

The completed *Driven by Lived Experience framework and strategy* will be published on the MHCC's website and provide foundational guidance for MHCC staff and the Advisory Council in their work.

When engaging with the Mental Health Complaints Commissioner

The MHCC honours and respects the collective experience and wisdom of mental health consumers, families and carers. This tree represents how our approach is driven by lived experience. The roots show what informs our work, and feed into the leaves which describe what we aim to achieve when people engage with the MHCC – the outcomes of our values in action.



Safeguarding rights and resolving complaints

Safeguarding people's rights through complaint resolution

A rights-based approach to complaints resolution means that the MHCC:

- assesses all complaints against the requirements of the *Mental Health Act 2014* (the Act), the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter) and relevant standards and guidelines
- immediately escalates complaints raising urgent concerns about people's rights or safety issues to ensure action is taken
- supports 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
- identifies areas where rights are not being adequately promoted and protected and ensures action is taken to address this
- holds services accountable for promoting and protecting the rights of consumers (e.g. through seeking enforceable undertakings where a breach of a person's rights or the requirements of the Act has occurred – see page 20)
- makes recommendations to improve the mental health service system based on what we learn through complaints.

A function of the MHCC under the 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 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. This informs how we 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 also 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, the DHHS and other relevant statutory bodies. This information informs our shared goal of ensuring safe, high-quality mental health services.

Our approach

[The MHCC] listened and actioned as appropriate.

— Consumer

I felt helpless and was equally concerned for many other individuals … They [MHCC] have been amazing at representing my issue … It is amazing to know that you can have a voice … Because when you are mentally unwell it may leave you stepping over your own words, or unable to comprehend certain things. But it doesn't make you forget good vs bad, nice vs abrupt, and caring vs non empathetic. I am very happy to know that my problem was represented with my best interest in mind.

— Consumer

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

- supporting people to raise their concerns directly with the mental health service
- using informal and formal dispute resolution processes such as reviewing service responses, conveying the responses to the person who has made the complaint and seeking their feedback, 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 having the power to issue compliance notices if appropriate.

Risk and safeguarding issues

I was struck by how kind you were to me as we talked about the process of the complaint… we both feel very confident that the complaint is in good hands. and remain grateful for the work you have done to date.

— Consumer

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's 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 or 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 from the service.

Undertakings and breaches of the Act

One of the Commissioner's options for dealing with complaints is to propose and 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.

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 and, where relevant, 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.

In 2019–20 the Commissioner sought and accepted four undertakings from services and was in the process of settling the terms of a further undertaking as of 30 June 2020. Four of the five undertakings related to acknowledged breaches of the Act – two were about the provisions for making an Assessment Order, and four concerned the legislative requirements for using bodily restraint.

One of the undertakings finalised in 2019–20 related to an incident where the Commissioner had concerns about the lawfulness of a contact search of a consumer without the consumer's consent. The terms of the undertaking required amendments to the service's policies and procedures in relation to the use of restraint and searches of patients, including to clarify the requirements for authorising contact searches. The undertaking also required the service to conduct an audit for a six-month period to identify whether there were other cases that raised similar issues. Clinical and security staff who may be involved in the use of restrictive interventions or searches of patients were also required to receive additional training in accordance with the terms of the undertaking. The complaint raised systemic issues about the adequacy of guidance provided by the Chief Psychiatrist about searches of consumers which has been the subject of a recommendation to the Chief Psychiatrist.

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.

Undertakings are usually 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[1]

I just wanted to reiterate my thanks to you and the rest of the team at MHCC. Your work is invaluable and has played an enormous part in giving me back my life and the power to eventually move on from what happened to me.

— Consumer

In 2019–20 more people contacted the MHCC to raise concerns or queries about their experiences than in any previous year. We received 2,369 new enquiries and complaints, comprising 2,221 complaints and 148 enquiries. The number of new enquiries and complaints has continued to increase each year, with an increase of 8 per cent from 2018–19.

Of the 2,221 complaints received in 2019–20, 1,558 were about people's experiences in Victorian public mental health services that were within the jurisdiction of the MHCC (known as in-scope complaints) (see Figure 1). The MHCC received a high number of complaints that were not about a public mental health service, consistent with our observations in 2018–19. 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.

1 Data was correct at the time of reporting, but may be subject to minor changes due to receipt of further information after 30 June 2020.

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 2018–19 (369), the MHCC dealt with 2,738 enquiries and complaints in 2019–20, a nearly 10 per cent increase on the 2,495 matters dealt with in 2018–19. Of these 2,738 matters dealt with in 2019–20, 1,927 were in-scope complaints. Figure 2 shows the continuing increase in total enquiries and complaints dealt with from the MHCC's commencement in 2014–15 to 2019–20. On average, 345 matters were open at any one time in 2019–20.

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 10002:2018). 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.

I'm really grateful for the support [name] has offered me in progressing with my complaint.

— Consumer

Figure 1

Breakdown of all complaints and in-scope complaints in 2019–20

This shows the number of complaints and enquiries received in 2019–20 (2,369 total, 2,221 complaints and 148 enquiries). Of the 2,221 complaints we received, 1,558 were ones we could help action (in-scope complaints). See Figure 14 (page 33) for a breakdown of in- and out-of-scope complaints.

In total, we actioned 1,927 complaints in 2019–20, including 369 that people made in earlier years.

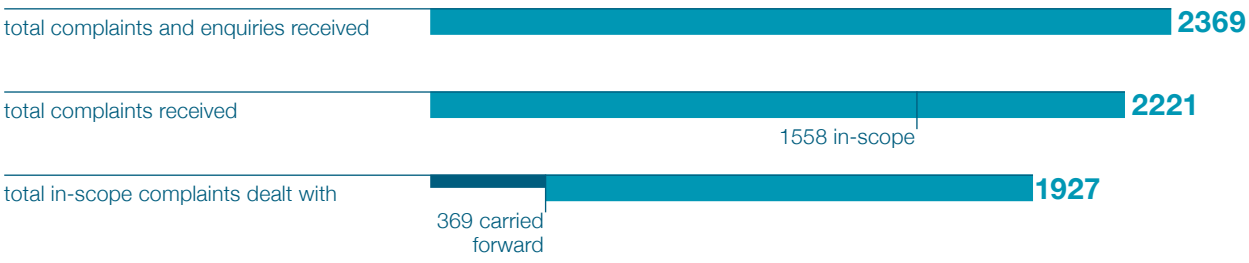


Figure 2

Year-on-year comparison of total enquiries and complaints

This figure shows the number of complaints and enquiries made to the MHCC each year since we opened – this has increased every year since 2014.

How people make complaints

Very warm and compassionate – clearly value the work they do and help people to see how important it is.

— Consumer

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. This phone line was maintained after the move to remote working arrangements due to the COVID-19 pandemic and continued to be the primary source of contacts with our office, with 78 per cent of all complaints made to our office in 2019–20 being 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 to put their complaint in writing if they have not already done so, 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 19 (see 'Risk and safeguarding issues').

Who made complaints to the MHCC?

Consumers raised 73 per cent (1,728) of 2,369 new enquiries and complaints made in 2019–20 (compared with 1,577 in 2018–19), and family members and carers raised 21 per cent (490 complaints and enquiries, a small decrease from 500 in 2018–19). The remaining complaints and enquiries were made by advocates, legal representatives, friends and staff from 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.

When the MHCC receives 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 for 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.

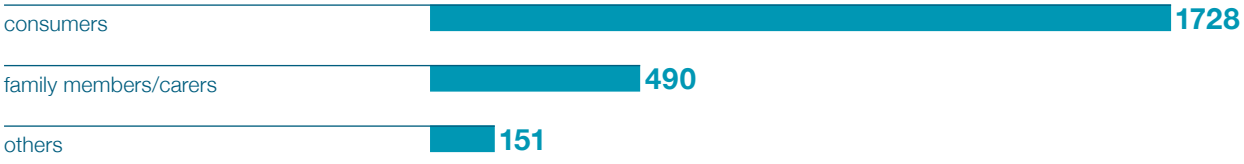
We recognise and respect the important role families and carers play in raising issues on behalf of a consumer. When we accept a complaint from a carer or family member, we first seek consent from the consumer and involve the consumer in resolving the complaint as much as the consumer wishes. Under the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

Figure 3

Who made enquiries and complaints?

Base: new enquiries and complaints raised with the MHCC (*n* = 2,369)

This shows who made enquiries or complaints to the MHCC. In 2019–20, 1,728 of the people who contacted us had received services themselves (consumers). Of the people who contacted us, 490 were family members or support people and 151 were advocates, lawyers, or service staff.



What type of services were complaints about?

Of the 1,558 in-scope complaints made to the MHCC in 2019–20, 1,507 (97 per cent) were about designated mental health services and 28 (two per cent) about mental health community support services (MHCSS). For 23 complaints (one per cent), not enough information was provided to determine the type of service the complaint was about. The higher proportion of complaints about designated mental health services 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. The MHCC's jurisdiction to deal with complaints about MHCSS services also reduced from 1 July 2019 when the responsibility for complaints about NDIS-funded supports was transferred to the NDIS Quality and Safeguards Commission. This resulted in a slight decrease in the proportion of complaints about MHCSS services, compared to 2018–19.

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

Of the 1,352 in-scope complaints made to our office in 2019–20 where a service program was identified[2]:

- 81 per cent were about adult mental health services, including forensic services
- 2 per cent were about MHCSS
- 4 per cent were about aged persons mental health services
- 9 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).

Fifty-four per cent of matters raised about adult services were about acute inpatient services, 31 per cent related to community mental health services, 10 per cent related to specialist forensic mental health services, three per cent were about other types of service (including secure extended care units and specialist inpatient services) and three per cent were about residential services (community care units and prevention and recovery care services). Just over half of complaints about CYMHS or CAMHS related to inpatient-based services (52 per cent), while most complaints about aged persons mental health services were about inpatient services (72 per cent).

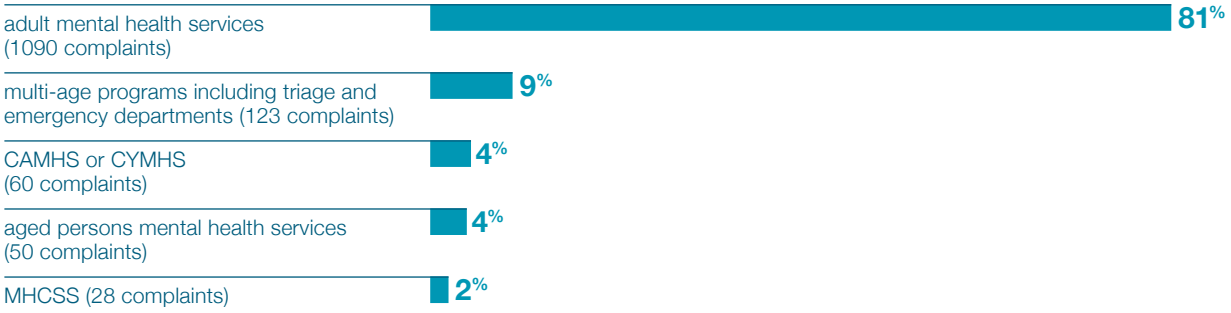
Prisoners can make complaints to the MHCC about mental health services in prisons that are provided by a designated mental health service. Approximately nine per cent of all calls to our office between 1 July 2019 and 31 December 2019 were made by prisoners, consistent with previous years.[3] Most of these calls were about prisoners' medication and access to assessments and reviews of their mental health. Many of these complaints were not in scope as they were about other services, and we referred the callers to other bodies as appropriate.

Figure 4

Service program breakdown

All in-scope complaints raised with the MHCC where service program and service type were identified (*n* = 1,351 see footnote 3)

This shows what types of services complaints were made about. 81 per cent of all complaints were about adult mental health services, 4 per cent each were about aged persons mental health and child and adolescent/child and youth services.



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.

3 This percentage has been calculated on data of 447 calls from prisoners for the period 1 July–31 Dec 2019 (of a total 4,817 calls for this period). Accurate calls data for the full financial year could not be extracted from the MHCC phone system due to remote working arrangements and restricted office access due to the COVID-19 pandemic.

What did people make complaints about?

They listened.

— Consumer

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 2019–20. 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, except for some of the smaller issue categories where examples would not otherwise be provided.

In 2019–20 treatment was the most common issue identified in new in-scope complaints (raised 2,744 times). Many complaints raised more than one issue about treatment as discussed below. Consistent with overall trends in previous years, the next most common issue was concerns about communication (raised 762 times), followed by issues about conduct and behaviour (raised 654 times) (see Figure 5).

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.

Complaints about treatment

Seventy-three per cent of in-scope complaints to the MHCC raised issues about treatment (2,744 issues in total). Many complaints raised more than one issue about treatment (see Figure 6).

Treatment complaints are broken down into several further categories:

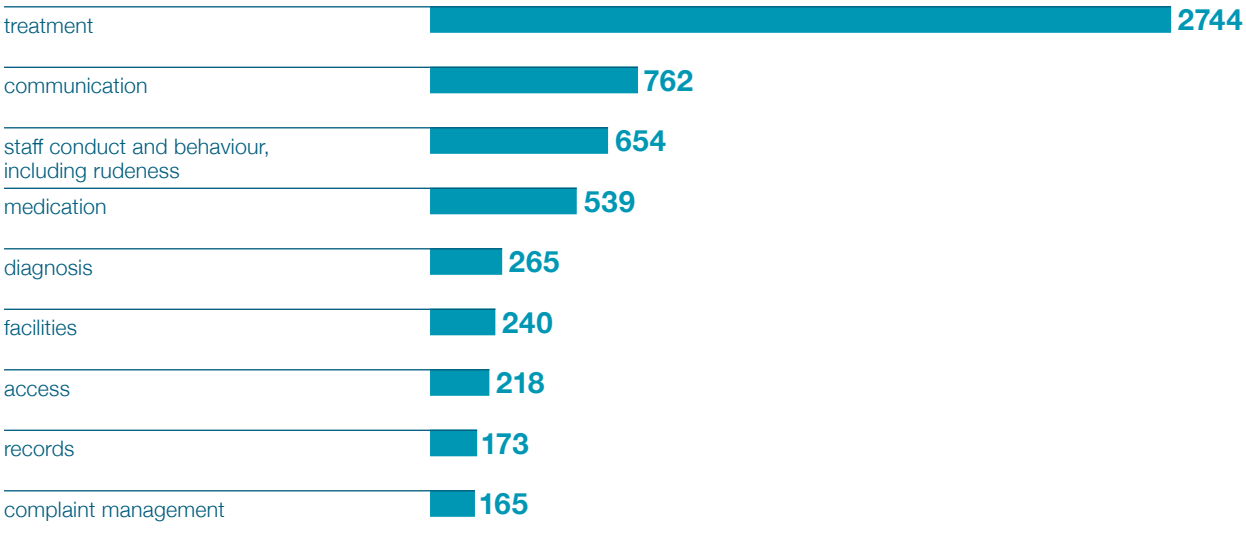
- suboptimal treatment[4] (raised 1,162 times). This category includes concerns about:
  - disagreeing with compulsory assessment or treatment
  - whether consumers' treatment was well planned and responded to their holistic needs, including medical or physical health needs
  - advance statements not being considered, and access to a second psychiatric opinion

Figure 5

What did people make complaints about in 2019–20?

Number of issues identified in in-scope complaints raised with the MHCC

This shows the types of issues people made complaints about. The most commonly raised issue was treatment, followed by communication, staff behaviour (including rudeness and lack of empathy) and medication.



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

– responsiveness of staff (raised 939 times), including concerns about how staff took the views and preferences of consumers, families, carers and nominated persons into account
– inappropriate discharge or transfer (raised 247 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 132 times), including concerns about whether restrictive interventions were necessary as well as whether legislative requirements for its use were met
– adverse outcomes (raised 100 times), including unexpected complications, physical or psychological injury and self-harm
– inadequate follow-up (raised 58 times), including no or inadequate follow-up after discharge.

COVID-19 related issues

Treatment issues have sometimes been raised in relation to COVID-19. In 2020, COVID-19 impacts on service provision and availability were raised 50 times in complaints to the MHCC. The issues raised included concerns about:

– consumers being discharged from acute inpatient treatment when they were still too unwell to understand COVID-19 risks and restrictions
– restrictions on visitors to services
– risk of infection in acute inpatient units or residential services
– approaches to infection control, including consumers being expected to stay in their own rooms and not access communal areas
– availability of community-based treatment and administration of medication
– suspension of leave from inpatient units, including leave for smoking.

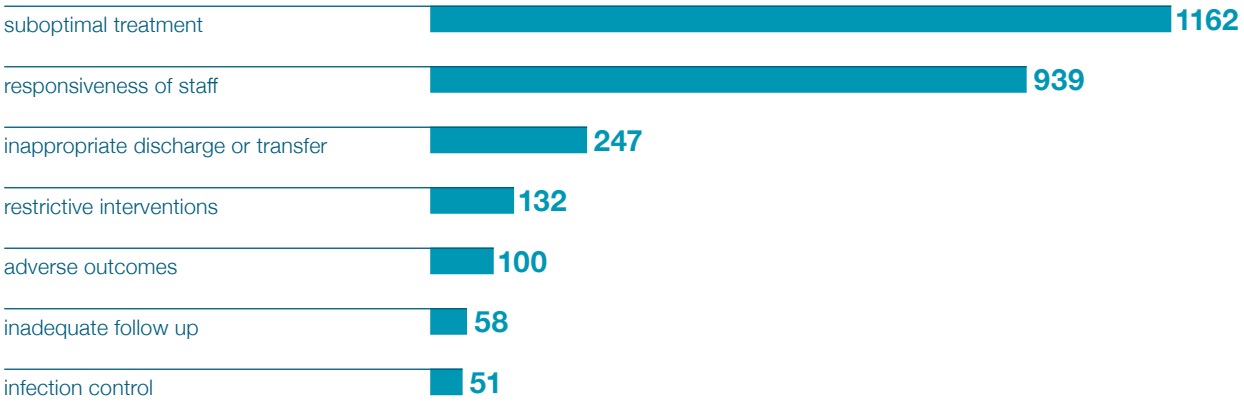
During this time, the MHCC met weekly with representatives of DHHS to share these themes from complaints to the MHCC, which were used to progressively inform the DHHS's mental health COVID-19 responses.

Other less frequently raised treatment issues included (in order of frequency) concerns about incorrect treatment, nutrition and other treatment issues.

The most common specific treatment issues were lack of consideration of the consumer's views and preferences about treatment for consumers who were compulsory patients, lack of care or attention (e.g. not feeling listened to or believed) 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.

Figure 6
What treatment issues did people make complaints about?

This shows a breakdown of the types of treatment issues people made complaints about. The most common issue, suboptimal treatment, includes complaints where people disagreed with compulsory treatment, followed by responsiveness of staff, which includes people not feeling that their views and preferences are heard.



Example complaint: COVID-19 impacts

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

Sam's complaint

Summary

Sam contacted us after he had been admitted to an inpatient unit during the early stages of the COVID-19 crisis. He was feeling very stressed by the restrictions in the unit and did not feel that he was receiving the support that he needed.

What Sam told us

Sam told us that his mental health had quickly deteriorated, and he felt very anxious when he was placed on a Temporary Treatment Order and admitted to an inpatient unit. He said that he did not feel supported by staff to implement strategies that he found helpful in managing his mental health, such as being able to access food of his choice and being in a calming environment. He also felt that the treating team were not considering his previous diagnoses, and the best way to support him holistically.

He described the environment in the inpatient unit as being very tense, with consumers being upset about the new restrictions, and not being able to access leave, including to smoke. Consumers were also not able to leave to get food of their choice at the hospital café because of the restrictions, or to have food delivered to them.

How the mental health principles applied to the complaint

The *Mental Health Act 2014* (the 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 Sam'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.

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.

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.

What do the principles mean for Sam?

Sam had the right to receive treatment in the least restrictive way possible, and in a way that responded to his individual needs and supported his recovery. The mental health principles also require staff to involve him in decisions about his treatment, and ways of achieving the best possible therapeutic outcomes. Mental health services are required to have regard for the mental health principles when providing services, including during the challenging times of dealing with risks and impacts of COVID-19 and the associated Public Health Directives.

Our involvement

From the outset of the COVID-19 crisis, the MHCC has actively engaged with the DHHS and the Office of the Chief Psychiatrist (OCP) to share information on the COVID-19 impacts for consumers and mental health services. The MHCC met weekly with the OCP and the DHHS representatives to discuss issues and concerns like those raised by Sam, and to clarify the guidance and directives being issued to mental health services. There was clear guidance to mental health services that they were required to have regard for the mental health principles when implementing the COVID-19 Public Health Directives and associated restrictions.

As there were immediate issues to address, we contacted the Nurse Unit Manager about Sam's concerns, and the impacts of the current restrictions on him, and also his observations of the impacts on other consumers. We also discussed his concerns about the lack of responsiveness of staff to his particular needs and his views and preferences about treatment. The Nurse Unit Manager spoke with Sam and looked into the issues he raised. As Sam was being discharged soon, he spoke about his desire for the service to improve the way that they were responding to the needs of consumers and consider ways to reduce the negative impacts of the COVID-19 restrictions. The Nurse Unit Manager discussed the following service improvement actions with Sam, which were implemented as an outcome of his complaint:

- *Access and choices of food:* The service increased the availability of food that consumers could readily access outside of meal times, and made other food available during COVID-19 restrictions to compensate for the fact that independent food delivery was not available to consumers during this time.
- *Directions to staff about smoking and supports for consumers:* The service updated their directions to staff in working with consumers who may be experiencing difficulties with not being able to smoke on the unit, or access leave. This included access to Nicotine Replacement Therapy (NRT) and QUIT programs.
- *Increasing a focus on therapeutic engagement with consumers:* The service acknowledged the issues raised by Sam about the lack of responsiveness of staff to his needs and preferences for treatment, as well as the current tensions and stress being experienced by consumers in the unit. The service advised that the consumer consultants were working with the staff on ways of addressing these issues, as well as planning training on therapeutic engagement for staff.

In response to Sam's concerns about his experience of treatment during his admission, the Nurse Unit Manager also provided information to him about the value of having an Advance Statement, which would outline his views and preferences for treatment, and would help to guide his treating team and staff if he was admitted again in the future.

We confirmed the agreed service improvement actions with the Clinical Director of the service and also alerted the service to options and resources being explored by the DHHS and the OCP to reduce the impacts on consumers of the restrictions on leave and visits to inpatient units. These options included further exploration of access to devices and data packages to assist consumers to keep connected with their families and support people during the COVID-19 restrictions, and access to NRT programs and new resources available through the QUIT program, to provide more support to consumers.

Outcomes

Sam advised that speaking with the Nurse Unit Manager about his concerns, and their direct response to his concerns, had helped to reassure him that steps would be taken to address the issues that he had raised, and to improve the experiences of other consumers. He said he felt that his concerns had been heard by the service and the MHCC, and that he appreciated knowing that we were ensuring that the emerging themes from complaints like his were being shared with the DHHS and the OCP to progressively inform the mental health responses to COVID-19.

Sam agreed that it was appropriate for MHCC to close the complaint, as he felt that his individual concerns had been resolved and was pleased that his complaint had contributed to service improvement actions and the broader COVID-19 mental health response.

Complaints about communication

Thirty-six per cent (762) of in-scope complaints to the MHCC raised issues about communication (see Figure 7).

Communication complaints are broken down into several further categories:

– inadequate communication with families/carers/other providers (raised 219 times): this category includes concerns about inadequate, incomplete or confusing information being provided to family members or carers, lack of communication with family members, carers or other providers, or inadequate open disclosure with family members or carers
– inadequate communication with consumers (raised 218 times): concerns about inadequate, incomplete or confusing information being provided to consumers, and inadequate open disclosure with consumers
– inadequate communication about rights (raised 186 times): concerns about inadequate communication of status under the *Mental Health Act 2014*, insufficient information about the Mental Health Tribunal process and appeal rights, and Statements of Rights not being provided or explained
– confidentiality and information privacy (raised 62 times): concerns about privacy breaches and information released or disclosed by staff without consent.

Other less frequently raised communication issues included (in order of frequency): other communication issues and consent to treatment.

The most common specific communication issue was inadequate, incomplete or confusing information being provided to consumers. The frequency of this issue points to the continued 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 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.

Complaints about conduct and behaviour

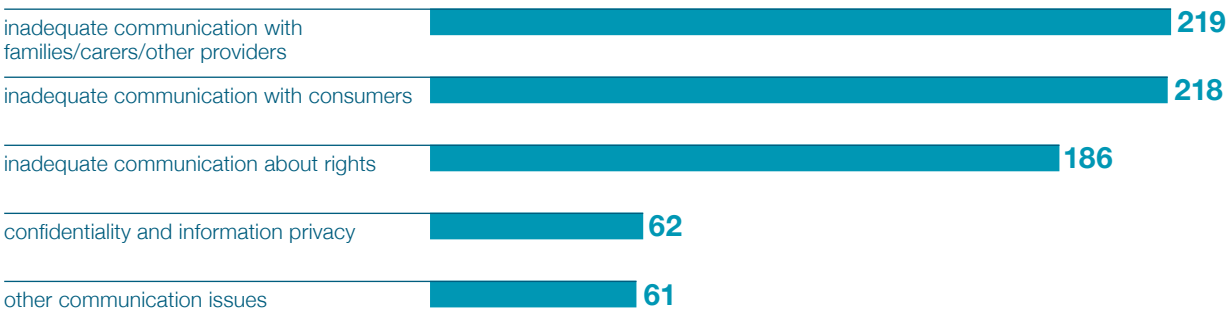
Complaints about conduct and behaviour were raised in 30 per cent of in-scope complaints to the MHCC (654 issues raised in 2019–20). These complaints are mainly about staff conduct; however, they also include allegations of sexual or physical assault, or threats, bullying or harassment by another consumer. 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 that will ensure people's safety, including their physical, sexual, psychological and cultural safety.

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

– rudeness/lack of empathy of staff was raised 316 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

Figure 7
What communication issues did people make complaints about?

This shows a breakdown of the types of communication issues people made complaints about. The most common issues were problems with how services communicated with families, carers, and consumers, followed by issues about how people were told about their rights, and concerns about privacy.



– alleged threats, bullying or harassment by staff (raised 75 times): includes alleged threats, bullying, harassment or verbal abuse by clinical or security staff
– other conduct and behaviour issues (raised 67 times)
– alleged discriminatory behaviour (raised 53 times): on a range of grounds, including gender, religion, sexuality, age, culture/language, diagnosis, disability or substance use.

There was also a range of less frequent but very concerning 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.

Examples of the types of action taken by the MHCC to deal with these significant conduct and safety issues are discussed under 'What other actions were taken to address risk and safeguarding issues?' (page 35) and 'Investigations' (page 38).

Complaints about medication

Twenty-eight per cent of in-scope complaints to the MHCC raised at least one medication issue (539 issues in total). Medication complaints are broken down into several further categories (see Figure 9):

– disagreement with medication (raised 213 times): concerns about unnecessary medication, dissatisfaction with prescribed medication and preference for oral over depot medication
– over-sedation and side effects (raised 193 times)
– medication errors (raised 50 times): concerns about wrong medication or dosage administered or omitted, wrong prescription or known allergy or reaction not considered.

Other less frequently raised medication issues included (in order of frequency): refusal to prescribe or dispense particular medications or other medication issues. The most common specific issue raised was side effects from medication. Medication issues frequently co-occur with concerns that a consumer's voice and preference has not been heard and highlight the need for a continued focus on the implementation of supported decision making.

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

This shows a breakdown of what types of complaint people made about staff behaviour. The most common issue was staff manner, including rudeness and/or a lack of empathy or compassion.

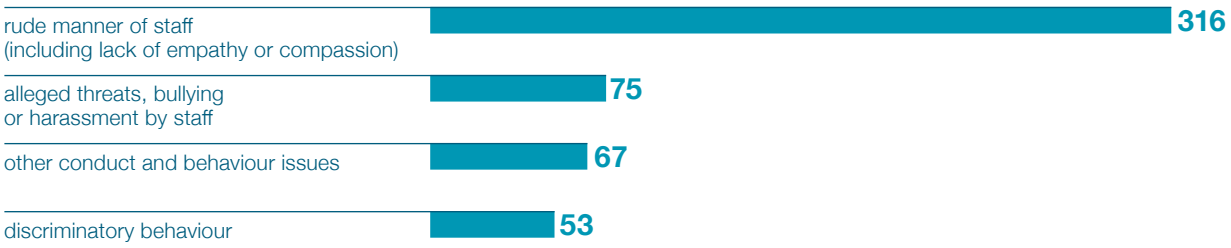
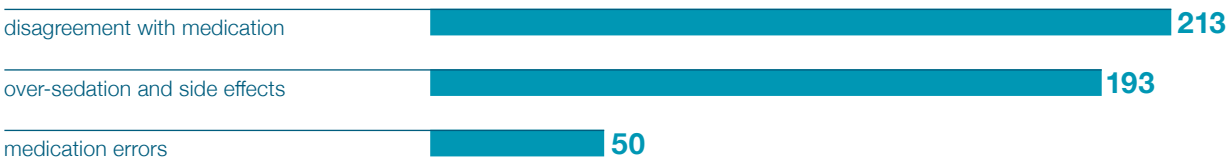


Figure 9
What medication issues did people make complaints about?

This shows a breakdown of the types of complaint people made about medication. The most common issue was disagreement with the type of medication or how it was administered. Other issues included concerns about side effects of medication and over-sedation.



Complaints about diagnosis

Concerns about diagnosis were raised in 15 per cent of in-scope complaints to the MHCC (265 issues (see Figure 10). This included complaints about:

– incorrect diagnosis (raised 171 times), including concerns about receiving an incorrect diagnosis or inadequate explanation of a diagnosis
– inadequate or inappropriate assessment (raised 85 times), including where a person believed the assessment process was inadequate or disagreed with the outcome of the assessment.

A less frequently raised issue was inadequate or inappropriate referral.

Complaints about facilities

Concerns about the adequacy of facilities were raised in 11 per cent of in-scope complaints (240 issues (see Figure 11). This included complaints about:

– security (raised 115 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 59 times), including concerns about food quality, issues with noise, lighting or the temperature of the facility or problems with bedding or furniture.

Less frequently raised issues included 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.

Complaints about access to services

Concerns about access to services were raised in 12 per cent of in-scope complaints to the MHCC (218 separate issues). This included complaints about refusal to assess or treat (raised 94 times): most of these complaints were about 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 frequently raised issues (in order of frequency) included lack of or insufficient access to services and service inaccessible due to distance/lack of public transport, delays in access, including delays in assessment or treatment, and other access issues.

Complaints about records

Issues about records kept by mental health services were raised in nine per cent of all in-scope complaints (173 issues in 2019–20, see Figure 12). This includes complaints about:

– record keeping (raised 119 times), including complaints about inaccurate or incomplete records, inadequate clinical documentation and requests to amend or correct records
– other records issues (raised 54 times), including complaints about access to records and transfer of records or of information critical to ongoing care.

Complaints about how a complaint was managed

Issues about how a complaint was managed by a mental health service were raised in 10 per cent of all in-scope complaints (165 issues in 2019–20). This includes complaints about:

– inadequate or no response (raised 124 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 raised included fear of, or a direct experience of, retaliation as a result of making a complaint and finding the complaint process difficult to navigate.

Closure

Time taken to close complaints

In 2019–20 we dealt with 2,590 complaints (excluding enquiries), made up of 2,221 received during the year (1,558 of which were in scope) and 369 carried forward from 2018–19. In total, 2,241 complaints were closed during 2019–20, with 1,573 of these being in-scope complaints.

Thirty per cent of all complaints were closed within one week, a further 33 per cent were closed within one month, 15 per cent within two months and six per cent within three months. The remaining 16 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. 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. The percentage of complaints that took more than three months to close is broadly consistent with previous years, despite the MHCC receiving 314 more complaints, and closing 344 more complaints in 2019–20 than in 2018–19. Most complaints open at 30 June 2020 (355) were written complaints at various stages of assessment, resolution or investigation.

Figure 10

What diagnosis issues did people make complaints about?

This shows a breakdown of the types of complaint people made about diagnosis, most commonly where the person disagreed with their diagnosis.

Figure 11

What facilities issues did people make complaints about?

This shows a breakdown of the types of complaint people made about facilities (e.g. food, accommodation, lost property). The most commonly raised concern was about security, including lost property and people not feeling safe.

Figure 12

What records issues did people make complaints about?

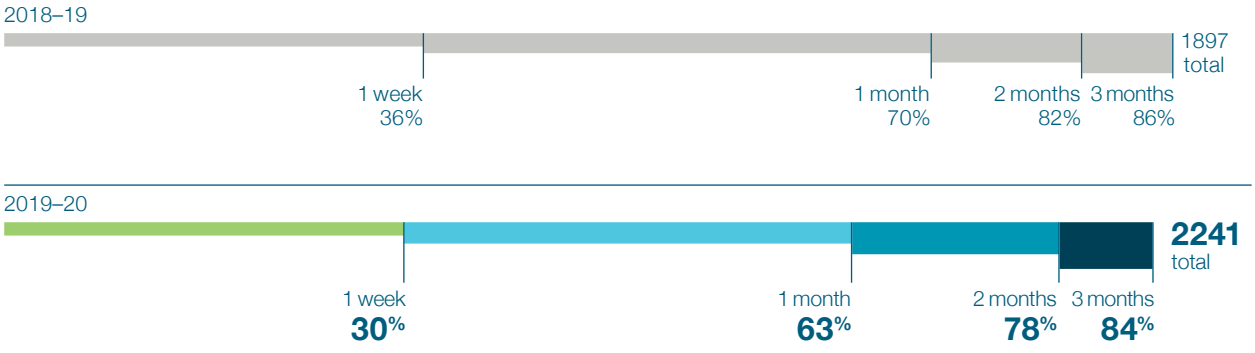
This shows a breakdown of the types of complaint people made about records. Most issues were about record keeping, particularly clinical notes.

Figure 13

How long did it take to finalise complaints?

Base: all complaints closed by the MHCC (*n* = 2,241)

This compares how long it took the MHCC to deal with complaints in 2018–19 to 2019–20. The MHCC took slightly longer to deal with complaints in 2019–20, which may be because we received more complaints in 2018–19 than in 2019–20.



Resolution not applicable/possible

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 (e.g. 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. For example, in 2019–20 we used our powers under s 242 of the Act to formally refer 11 complaints that were not within our jurisdiction to other bodies including the DHHS, the Health Complaints Commissioner, the NDIS Quality and Safeguards Commission and Office of the Public Advocate. We provided 'warm', or informal referrals in a further 43 out-of-scope complaints, mainly supporting people to contact the Health Complaints Commissioner.[5]

Complaints about public mental health services

Of the 2,241 complaints closed in 2019–20, 1,573 were in scope. The remainder of the closed complaints (668) were matters that the MHCC was unable to deal with and are referred to as out of scope (see Figure 14).[6] The main reason that complaints were out of scope was because they were not about a public mental health service (623, or 93 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 attributable to the media coverage of the Royal Commission into Victoria's Mental Health System and its broader focus on mental health services.

Of the 1,573 closed in-scope complaints, 819 complaints were dealt with through detailed assessment and resolution processes and a further 188 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 (566) were assessed as resolution not applicable/possible.

How many complaints were resolved?

Of the 819 closed complaints that were dealt with through detailed assessment and resolution processes, 673 (82 per cent) had positive outcomes and actions for consumers, families and carers. The remaining 146 closed complaints (18 per cent) were not resolved. This is the same as the percentage of complaints closed through detailed MHCC assessment and resolution processes that were not resolved in 2018–19. The reasons why it is not possible to achieve positive outcomes for all complaints are discussed below.

In the 819 complaints closed through detailed MHCC assessment and resolution processes:

- 26 per cent (214) were fully or substantially resolved
- 56 per cent (459) were partially resolved
- 18 per cent (146) 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.

This number of 819 complaints closed through our detailed assessment and resolution processes substantially increased from 2018–19 (427 complaints) and 2017–18 (357 complaints). The MHCC believes this is largely due to work done to improve consistency about how we record closure outcomes and actions. As of 30 June 2020, 355 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.

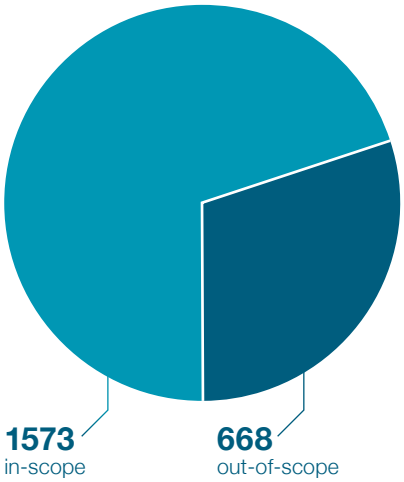
5 24 referrals were also made in relation to in-scope complaints, with 78 referrals made in total.

6 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 closed 668 complaints that were out of scope in 2019–20.

Figure 14

In- and out-of-scope complaints

Base: complaints closed (*n* = 2,241)

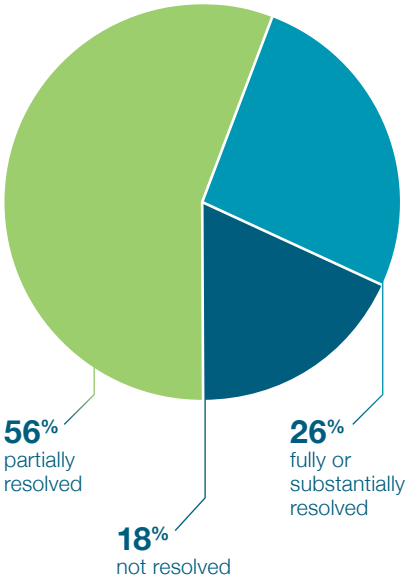


This shows a breakdown of the complaints the MHCC received in 2019–20. We received 1,573 complaints that we could deal with (in-scope complaints) and 668 complaints that we didn't have the power to deal with (out-of-scope complaints).

Figure 15

How many complaints were resolved?

Base: in-scope complaints closed through detailed MHCC assessment and resolution processes (*n* = 819)



This shows how satisfied people were with the outcome of their complaint. Of all complaints that were closed after a resolution process, 26 per cent of people were completely, or nearly completely satisfied with the outcome, 56 per cent of people were satisfied with some of the outcome, and 18 per cent of complaints were not resolved.

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 4 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?

Great advice and support in resolving complaints.

— Consumer

The outcomes of the 819 in-scope complaints closed by MHCC where resolution actions were taken by either the MHCC or services are categorised by the 4 As of complaints resolution. Note: most of the complaints had more than one resolution action:

- 813 or 99 per cent showed the MHCC or the service had acknowledged the person's experience
- 806 or 98 per cent showed that action had been taken by either the MHCC or the service because of the complaint
- 762 or 93 per cent resulted in explanations or answers about the complaint issues
- 177 or 22 per cent resulted in an apology from the service (see Figure 16).

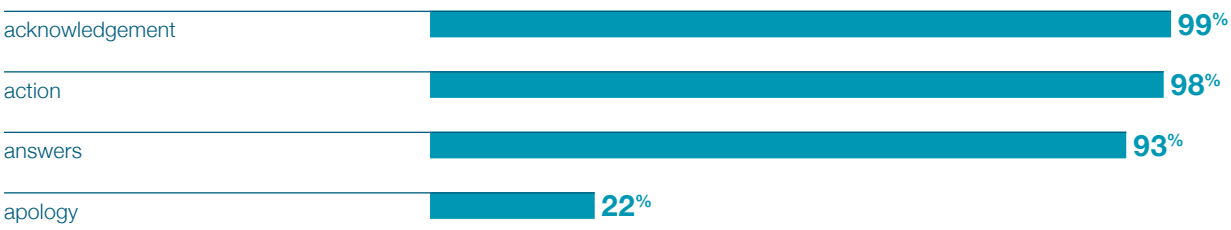
In 2019–20, the MHCC started to record resolution actions taken by the MHCC and services separately. Resolution actions undertaken by the MHCC for the 819 closed in-scope complaints were categorised by the 4 As as follows:

- 799 or 98 per cent showed that the MHCC had acknowledged the person's experience
- 802 or 98 per cent showed that action had been taken by the MHCC in relation to the complaint, most frequently providing advice or suggestions on ways to resolve the complaints, contacting the service for information or clarification, or facilitating the complaint to the service for follow-up. The MHCC made 20 formal referrals under s 242 of the *Mental Health Act 2014* for in-scope complaints, including to the Australian Health Practitioner Registration Agency, the Health Complaints Commissioner, the Chief Psychiatrist, and health service providers. The MHCC also made four 'warm', or informal referrals.
- 627 or 77 per cent resulted in the MHCC providing answers or explanations, including information about the MHCC's and services' complaint processes and about other bodies.

Resolution actions undertaken by the service for the 819 closed in-scope complaints were categorised by the 4 As as follows:

- 707 or 86 per cent showed that the service had acknowledged the person's experience
- 615 or 75 per cent showed that the service had taken action in response to the complaint
- 560 or 68 per cent showed that the service had provided answers or explanations in relation to the complaint
- 177 or 22 per cent of complaints resulted in the service making an apology.

Figure 16
What happened when people made a complaint?
Base: in-scope complaints closed through detailed MHCC assessment and resolution processes (*n* = 819)



Apologies and acknowledgements by services 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 taken by services 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 2019–20, 148 service improvements were recorded in relation to complaints, including those that progressed to an investigation. 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 53–61.

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 and review teams to determine the most appropriate action.

In 2019–20, 36 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. Five of these complaints were subject to two or more processes, such as investigation and conciliation:

- formal investigations (2 completed, 3 in progress at 30 June 2020)
- follow-up of implementation of recommendations made as part of formal investigations (3)
- referral to conciliation for potential settlements (2 current, 2 closed)
- undertakings from services: formulation of terms and agreements for undertakings and monitoring of agreed actions (4 current, 2 pending)
- requests of clinical records and/or incident reports and other service documents and examination for safeguarding issues and potential breaches to determine appropriate actions (12)
- review of coronial briefs and findings (2)
- formal referrals to other bodies to consider issues outside MHCC's jurisdiction, including to the Chief Psychiatrist to review alleged practice issues (4), AHPRA to investigate alleged staff misconduct (2), the Health Complaints Commissioner to assess an alleged breach of the *Health Records Act 2001* (1), and the Commonwealth Ombudsman to review actions of Federal Police attending a mental health service (1)[7]
- formal request for review of the outcome of a referral made in respect to alleged conduct issues of an NDIS provider (1).

All of 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. Most of these complaints involved detailed review of the clinical records and processes which elicited detailed accounts from the consumer of their experience. An example of the range of actions that the MHCC has taken to address significant safeguarding issues in complaints is provided at page 40. The issues identified in five of these complaints also informed formal recommendations to the Secretary of the DHHS which are outlined on pages 56–58.

The MHCC's approach to investigations and the types of complaint that are referred to these processes are discussed below.

7 The MHCC made 78 referrals overall in 2019–20.

Example complaint: self-harm

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

Kelly's complaint

Summary

Kelly was admitted to a mental health inpatient unit experiencing suicidal thoughts. During the admission Kelly made two suicide attempts in a similar manner over successive nights. Kelly and Sara, her partner and carer, were very distressed by the experience as they did not feel that the service had appropriately responded to Kelly's needs and had failed to keep her safe during the admission. Sara was also disappointed by the service's communications with her, which she felt did not respect or support her role as a carer.

What Kelly and Sara told us

Kelly had been experiencing suicidal thoughts and was voluntarily admitted to a low dependency unit in a mental health inpatient service. On the first evening of the admission, Kelly attempted suicide in her room but was found by staff who intervened before serious physical harm occurred. Kelly was then moved to the high dependency unit and her risk status and level of nursing observation increased.

Sara arrived to visit Kelly the following morning and was informed by a nurse about Kelly's suicide attempt the previous evening. Sara told us that she was very upset that she was not notified overnight and that she was told in a public section of the unit when she arrived, without any privacy.

That evening, Kelly attempted suicide again in the high dependency unit in a similar manner to the previous evening. A 'code blue' alert was called due to the seriousness of Kelly's injuries and she was rushed to the intensive care unit and intubated. She was later discharged after her recovery from this incident.

Following Kelly's discharge, Sara made a complaint to the MHCC about their experiences with the service and the physical and psychological impacts of these incidents on Kelly.

How the mental health principles applied to the complaint

The *Mental Health Act 2014* (the 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 Kelly and Sara's complaint are:

b Promote recovery

People 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.

k Involve carers

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

What do the principles mean for Kelly and Sara?

Kelly had the right to expect that the service would keep her safe while she was experiencing suicidal thoughts, especially following the first suicide attempt.

Sara, as Kelly's partner and carer, had the right to expect to be contacted as soon as possible about an incident as serious as a suicide attempt and to be provided with privacy and support by the service.

Our involvement

After hearing Sara's concerns, we contacted Kelly with her consent. Kelly agreed to Sara making the complaint on her behalf. We assessed that Kelly's and Sara's complaint raised serious issues of rights, safety and quality, along with questions about the adequacy of the level of care and risk management in response to Kelly's needs.

In consultation with Sara and Kelly, we requested detailed information from the service to assess the actions it took when providing mental health services to Kelly, and to understand whether it had implemented improvements in response to their complaint.

Once information was received from the service, we conducted a detailed assessment, which included reviewing clinical records, incident reports, policy and procedure documentation and the service's responses to the complaint. In its responses, the service provided apologies to both Kelly and Sara for their experiences, including an acknowledgement that it did not comply with the service's open disclosure[8] policy in its communications about Kelly's suicide attempts.

We shared the service's responses and the outcome of our assessment with Kelly and Sara and sought their views. The option of conciliation was explored but due to particular circumstances was not pursued. Kelly and Sara had been clear from the outset that they wanted the complaint to lead to changes which would prevent others from having similar experiences. We assessed that the service had not adequately identified or managed the risks that were evident after Kelly's first suicide attempt, and that there were a range of other practices and policies that warranted review and service improvements.

Outcomes

As part of the agreed closure of this complaint, we wrote to the service setting out our assessment of the complaint issues and made a number of recommendations for service improvement. We also requested the service provide a written acknowledgement of Kelly's and Sara's experiences and the service's commitment to implementing service improvements. The MHCC's assessment highlighted the need for effective engagement with consumers and carers on safety planning, risk management, open disclosure and the treatment of suicide attempts as sentinel events[9] requiring comprehensive review and preventative actions. The MHCC's recommendations focused on the service reviewing its policies and procedures, and providing guidance and training to staff in respect of ensuring:

- appropriate communication with consumers, families and carers following a suicide attempt, including training in open disclosure requirements and in considering what debriefing and ongoing support is required
- safety planning and engagement with consumers, families and carers following a suicide attempt, including ensuring staff comprehensively review all aspects of the suicide attempt, take appropriate steps to ensure the consumer's ongoing safety and consider the most appropriate level of observation for the consumer based on their individual needs and circumstances
- suicide attempts are reported and reviewed accurately, including appropriate reporting of incidents resulting in serious harm or death as sentinel events to Safer Care Victoria and ensuring consumers, families and carers are involved in the review process and ways of preventing similar incidents are identified
- accurate, detailed and timely documentation, particularly in relation to risk management and safety planning.

The MHCC will monitor the service's progress in addressing the recommendations at future meetings with the service. We also made recommendations to the Secretary of the DHHS, the Chief Psychiatrist and Safer Care Victoria to consider the issues identified in the complaint in future reviews of suicide attempts in mental health inpatient units in order to inform system-wide strategies to address these tragic events in mental health services.

8 Open disclosure describes the way clinicians communicate with and support patients, and their family and carers, who have experienced harm during health care. Australian Commission on Safety and Quality in Health Care 2013, *Australian Open Disclosure Framework*, ACSQHC, Sydney, p 10.

9 Sentinel events are broadly defined as wholly preventable adverse patient safety events that result in serious harm or death to individuals. Safer Care Victoria 2019, *Victorian sentinel event guide*, State Government of Victoria, Melbourne, p. 3.

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), provided that this will not unreasonably breach the privacy of the consumer.

In accordance with the 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 2019–20

In 2019–20 we started formal investigations of two complaints that raise serious issues about the lawfulness of action taken by services and staff and the rights of people subject to compulsory treatment under the Act. The investigations relate to:

- the circumstances in which a consumer was placed on an Assessment Order and taken to an acute inpatient unit, including the role of CATT clinicians in the decision making on the involvement, apprehension and transport of the consumer by police and ambulance, and the adequacy of consideration by CATT clinicians of less restrictive ways to provide treatment and care
- the circumstances in which electroconvulsive treatment was administered to a consumer who also required medical treatment in an intensive care unit, and who was sedated and mechanically restrained for long periods.

We also continued work on an investigation about the experience of a consumer who was mechanically restrained by security officers and police in the emergency department of a hospital, and who was restrained throughout the night. The MHCC completed a draft of the investigation report in 2019–20. We requested comments on the draft report from the service and affected staff to meet the legal requirements of procedural fairness before finalising the report. The timeframe for this process was extended in recognition of the impacts of the COVID-19 pandemic on the service, which meant that the report could not be finalised in 2019–20. The preliminary findings of this investigation, however, informed recommendations made to the Secretary of the DHHS and the Chief Psychiatrist which are discussed in 'Promoting service and system improvements page 53.

The MHCC will report on the outcomes of these three investigations in the 2020–21 annual report.

Key issues identified in investigations concluded in 2019–20

In 2019–20 we concluded two investigations:

Investigation relating to the use of mechanical restraint

One of the investigations related to the experience of a consumer who was mechanically restrained in the emergency department of a designated mental health service.

Mechanical restraint is a highly intrusive practice that can only lawfully be used in the strictly limited circumstances set out in the *Mental Health Act 2014* (the Act), and subject to the statutory safeguards and protections. The Act is clear that a person must immediately be released from mechanical restraint when it is no longer necessary to prevent imminent and serious harm or to administer treatment.

The investigation considered a range of factors, including the requirements of the Act for authorising and reviewing the use of restraint, compliance with the Chief Psychiatrist's guideline for the use of restrictive interventions, and the roles and responsibilities of medical staff, nursing staff and mental health staff rostered to work in the emergency department.

The Commissioner found that the consumer was mechanically restrained for a period of approximately seven hours more than could be reasonably justified, in breach of section 113 of the Act and the Charter of Human Rights and Responsibilities.

One of the overall findings of the investigation was as follows:

> *I find that there was a combination of factors that resulted in a profound systems failure which led to effective violations of [the consumer's] right to receive the least restrictive treatment under the Act and [the consumer's] rights under the Charter of Human Rights and Responsibilities Act 2006 (Charter) to be protected from cruel, inhuman and degrading treatment (Charter s 10(b)) and to be treated with humanity and with respect for the inherent dignity of the human person when deprived of liberty (Charter s 22(1)).*

The Commissioner also found that the experience had a profound and enduring impact on the consumer and reflected a desensitisation of staff to the gravity of the use of restraints.

The investigation report noted that the service had implemented significant policy, process and system changes to reduce the risk of a reoccurrence of the consumer's experience and to change the culture of complacency about the use of restraint. Accordingly, the Commissioner made recommendations to strengthen those changes and test whether the strategies had been effective and sustained over time.

The service accepted all of the MHCC's recommendations for service improvement and has reported to the MHCC as work progresses to complete the actions required. The service is also working with the MHCC on a proposed conciliation with the consumer.

Investigation of allegations of assault and verbal and physical abuse by staff

In 2020 the MHCC finalised an investigation into allegations about staff in an aged acute mental health unit. The consumer was subject to a Compulsory Treatment Order under the Act and staff used a range of strategies to persuade the consumer to take oral medication. This was the context of the consumer's reported experiences of harassment, bullying and intimidation by staff, and also of allegations of assault.

While the investigation concluded there was insufficient evidence to substantiate the assault allegations or make a finding that staff acted inappropriately, the consumer's experiences of feeling coerced by staff was acknowledged. The Commissioner noted that the consumer's adverse experiences reflected the conflicts and potential coercive treatment which can occur when a person objects to the prescribed medication but is required to take it pursuant to a compulsory order and treatment decision made by the authorised psychiatrist under the Act.

The investigation report included recommendations to the service to improve consumers' experiences, including recommendations for staff training and development in relation to approaches to responding to people's needs and interventions for reducing conflict and responding to challenging behaviour within a human rights framework. Recommendations were also made about the model of care provided, and approaches to debriefing and review of incidents for both consumers and staff. The service accepted all of the MHCC's recommendations and will report to the MHCC as work progresses.

The consumer and the service also participated in a meeting facilitated by the MHCC after the investigation was finalised. This meeting provided the opportunity for the service to acknowledge the consumer's experience, to discuss service improvement actions and ways of improving the consumer's individual experience of treatment in any future admissions. The consumer provided positive feedback about the meeting and expressed confidence that positive changes had been made by the service.

Example complaint: mechanical restraint

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

Michelle's complaint

Summary

Michelle contacted us about two incidents of being mechanically restrained[10] in an emergency department (ED) after being assessed as being at risk of self-harm. She was very distressed and traumatised by her experiences and upset that the service had not sought or listened to her views about what would have helped to prevent the use of restraint.

What Michelle told us

Michelle described the first incident of being placed in mechanical restraints during an ED admission as horrific. She had been placed on an Assessment Order and assessed as being at risk of leaving the hospital. She remained in the restraints for hours and was not reviewed by a doctor. She spoke of the shock of only being offered a bedpan to use while in four-point restraints, instead of being allowed access to a toilet. Michelle described the ongoing trauma and distress associated with that experience. She also spoke about how her severe anxiety and sensory sensitivities could be adversely affected by being in a busy ED environment, which together with attempts to force her to take medication, could lead to her attempting to leave the ED.

On the second occasion, Michelle told us that when she became distressed by the ED environment and wanted to leave, she was mechanically restrained for three hours. She said that she tried to explain her distress and what would help to her to staff, but it was really difficult. This further experience of restraint caused her significant pain, emotional distress, and trauma.

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

The *Mental Health Act 2014* (the Act) protects the rights of people who are 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 section 11(1) of the Act and meet the requirements in Part 6 of the Act in respect of any use of restrictive interventions, including the use of mechanical restraint. The Act states that restrictive interventions can only be used to 'prevent imminent and serious harm to the person or another person' or to 'administer treatment' and 'after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable'.[11] The Victorian Government shares a national commitment to the goal of eliminating restrictive interventions in mental health services.[12]

Mechanical restraint is a highly intrusive practice that can only lawfully be used in the strictly limited circumstances set out in the Act and is subject to the statutory safeguards and protections. The Act is clear that a person must immediately be released from mechanical restraint when it is no longer necessary to prevent imminent and serious harm or to administer treatment. The Chief Psychiatrist's guideline on restrictive interventions emphasise that they should only be used as a last resort, and can cause serious trauma, re-traumatisation of past experiences, and injuries.[13] Michelle's complaint highlighted the traumatic and enduring impacts that can often be associated with the use of mechanical restraint.

10 Mechanical restraint involves 'the application of devices (including belts, harnesses, manacles, sheets and straps) to restrict a person's movement'. Department of Health 2015, *Chief Psychiatrist's guideline: Restrictive interventions in designated mental health services*, State Government of Victoria, Melbourne, p. 3.

11 Sections 105 & 113 of the Act

12 Australian Health Ministers' Advisory Council 2016, *National principles to support the goal of eliminating mechanical and physical restraint in mental health services*.

13 Department of Health 2015, *Chief Psychiatrist's guideline: Restrictive interventions in designated mental health services*, State Government of Victoria, Melbourne.

In addition, the mental health principles relevant to Michelle's complaints 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.

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.

e Promote rights, dignity and autonomy

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

These principles and requirements of the Act also need to be interpreted in conjunction with the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the Charter).

What do these requirements and principles mean for Michelle?

The Act requires the mental health service to respect and promote Michelle's rights, dignity and autonomy, which includes her right under section 10 of the Charter not to be treated or punished in a cruel, inhuman or degrading way. Michelle's experiences of mechanical restraint, and not being allowed access to a toilet, raised serious issues about the consistency of the service's practices with these principles and requirements of both the Act and the Charter. She experienced the restrictive interventions by the service as not respecting her human rights and dignity.

Michelle also had the right to be involved in decisions about her assessment, treatment and recovery, and for the service to identify the least restrictive way possible for her to be assessed and treated. The Act also required the service to work with Michelle with the aim of achieving the best possible therapeutic outcome from her experience of seeking help.

Our involvement

The MHCC assessed that Michelle's complaints raised serious issues of rights, safety and quality in the service's treatment of Michelle and questions as to whether there had been breaches of the Act and the Charter. As part of its assessment, the MHCC requested the service to provide a response to the identified issues and copies of the clinical records.

In response to the MHCC's request, the service acknowledged that the requirements of the Act had not been met in the notification and monitoring requirements for the use of such restraint and agreed to work with the MHCC on ways of addressing both the issues of compliance with the Act and providing a meaningful resolution and response to Michelle's experience.

In these circumstances, it was not necessary to conduct a formal investigation to determine the details of what had occurred. The MHCC completed a detailed assessment of the clinical records which identified issues in the decision making on the use of restraint. While it was clear that the service was worried for Michelle's safety and the risk of harm if she left the hospital, the records indicated that regular reviews had not been conducted with Michelle to consider other ways of responding to her needs and to assess whether the continued use of restraint was necessary.

In its response to Michelle's complaint, the service acknowledged the serious issues identified in their review of her treatment and initiated a number of service improvement actions to prevent similar incidents occurring in EDs, including staff training on the requirements of the Act and ways of reducing the use of restrictive interventions. In outlining the MHCC's assessment of the complaint issues, the MHCC also highlighted the ways in which the service's practices were inconsistent with the mental health principles and the requirement to uphold Michelle's rights under the Charter, particularly in responding to her request for access to a toilet and her right to be treated with dignity.

In recognition of the gravity of the identified issues, the service agreed to provide a legal undertaking to the MHCC to take a number of remedial actions to address the compliance issues identified in the complaint, in addition to service improvements already initiated by the service in response to the complaint. These actions included the implementation of revised policies and practices to address the issues identified by the MHCC, including staff training on the requirements and principles of the Act and rights under the Charter, and an audit of compliance with the provisions of the Act in the service's EDs relating to the use of restrictive interventions. A legal undertaking to the MHCC is an important regulatory tool to promote compliance with the Act and enables the MHCC to formally monitor the outcomes of actions taken and issue a compliance notice if the agreed actions are not taken.

In addition to the legal undertaking, the MHCC also worked with Michelle and the service on ways in which her individual concerns could be addressed and resolved, and to inform service improvement actions. The MHCC facilitated a meeting between Michelle and the service which provided Michelle the opportunity to communicate her experience to senior staff, including the Clinical Director of the service, and for the service to hear and acknowledge the impacts of both incidents on Michelle, and discuss actions that were being taken to prevent similar experiences for other people. The Clinical Director also apologised to Michelle during the meeting, which she felt was genuinely given.

In addition to the service improvement actions included in the legal undertaking, the following outcomes were agreed on at the meeting:

- the service would develop an ED Care Plan for all of the service's EDs, with Michelle's input
- the Manager of the ED would provide Michelle's feedback to the staff referred to in the complaints.

After the meeting, the MHCC followed up with the service to confirm that these actions had been completed. The service told the MHCC that they had also asked Michelle to contribute to an educational video for ED staff about the immediate and longer-term impacts of restrictive interventions on consumers.

The MHCC also spoke with Michelle, who said that it had been helpful to sit down and provide her personal experience at the facilitated meeting and that she was grateful for the verbal apology. However, at the time she had not thought to ask for an apology in writing. She asked the MHCC if the service could provide a simple unreserved written apology and acknowledgement of the distress caused to her, feeling that this would validate her experience and help her to put the past behind her.

The MHCC liaised with the service, and the Clinical Director of the service sent Michelle a simple, personal and very powerful apology which said, 'I apologise without reservation for your experience'. As well as providing this apology, the Clinical Director thanked Michelle for meeting with the service, and acknowledged that the restraint was unnecessary, not the least restrictive treatment possible and that it did not respect her dignity. The letter also expressed gratitude to Michelle for helping the service to develop a video describing the experience of being restrained with the aim of educating all staff and achieving cultural change.

Outcomes

Michelle later told us that she was very pleased with the outcomes of her complaint. She found the process of working with the service to develop the ED Care Plan very positive. She also spoke of the value of working with the service on developing an educational video, which aims to help staff to understand the importance of responding to people's views and preferences to prevent the use of restrictive interventions.

In talking about the positive outcomes of her complaint, Michelle highlighted the importance of the service's acknowledgement of her experiences, the actions they had taken and the apology she had received. She advised us that she was happy with the written apology, and that her relationship with the service has become a productive and therapeutic one and enabled her to feel supported in her recovery. Michelle was keen for her experience to be shared to inform other services and people about the impacts of restrictive interventions and how their use can be prevented.

The MHCC closed the complaint on the basis of Michelle's satisfaction and the actions taken by the service but continued to monitor the outcomes of the service improvement actions through the legal undertaking for the agreed period.

We also provided a copy of the undertaking to the Secretary of the DHHS and the Chief Psychiatrist. Including Michelle's experience as an example, the MHCC made a number of recommendations to the Secretary of the DHHS and the Chief Psychiatrist to address the systemic issues identified in complaints and investigations on the use of mechanical restraint in EDs (see 'Promoting Service and System Improvements' page 53).

Local complaints reporting

Our role

Under the *Mental Health Act 2014* (the Act), all public mental health services are required to provide reports about complaints they receive to the MHCC at intervals specified by the MHCC and containing the information requested by the MHCC.[14] Public mental health services include designated mental health services and mental health community support services (MHCSS).

Our approach

The MHCC collates and analyses complaint data received from mental health services to identify quality and safety issues and compares it with data about complaints made to us 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 DHHS to inform service improvements. We also use the data to gain insights into the concerns and experiences of consumers, families and carers which informs our input into other bodies' consultations and formal submission processes.

We usually report complaint data on a financial year basis to align with other reporting undertaken by services. We requested and received data from designated mental health services for July–December 2019 in early 2020. We did not request data from MHCSS due to the need to clarify which services remain within the MHCC's jurisdiction following the full implementation of the NDIS. We also did not request January–June 2020 complaint data in recognition of the impact of the COVID-19 pandemic on services. We will be requesting the remaining complaint data for the 2019–20 reporting period in early 2020–21 and will provide the analysis of this data through the production of individual service provider complaint reports and an updated report on statewide complaints trends on the MHCC website.

Therefore, the data and analysis that are provided in this section of the annual report are based on July–December 2019 data from designated mental health services only.

Provision of 2017–18 individual service provider complaint reports

In late 2019, we distributed individual service provider reports about complaints to designated mental health services,[15] to assist in identifying quality and safety issues and informing service improvements. These individual service provider reports showed comparative data over three years from 2015–16 to 2017–18. They included comparisons between MHCC complaint data and sector-wide complaint data reported by services as well as comparison of the rate of complaints per 1,000 consumers for service and MHCC complaints at an individual service level. The reports aim to enable services to identify key areas where their complaint processes and people's experiences could be improved.

Statewide complaints trends

We have also published a report on the MHCC website that compares statewide trends in complaints to the MHCC and services about designated mental health services from 2015–16 to 2017–18 (inclusive). Individual service provider reports that compare data for 2017–18 to 2019–20 (inclusive) will be distributed in 2020–21.

14 Prior to amendments made in October 2019, the Act required services to provide biannual reports and specified that these reports included the number and outcomes of complaints. This section was amended so that service providers would have to provide reports at 'intervals specified by the Commissioner', that contain 'information required by the Commissioner'.

15 The numbers of complaints reported and made about individual mental health community support services were too small to make a comparative report meaningful.

Using complaint data to inform system improvement

The MHCC has provided the complaint reports for 2015–16 to 2017–18 to the DHHS, Safer Care Victoria (SCV), and the Victorian Agency for Health Information (VAHI).[16] These reports have been provided to promote the use of complaints data alongside other indicators of quality and safety, in order to inform broader service and system improvements. This sharing of information for quality and safety purposes is consistent with the recommendations of *Targeting Zero, the Report of the Review of Hospital Safety and Quality Assurance in Victoria* (Victorian Government, 2016).

The MHCC has also provided the 2015–16 to 2017–18 reports to the Royal Commission into Victoria's Mental Health System to enable themes raised in complaints to be compared to other experiential and incident data. This supports the Commission to understand the nature of people's experiences across the mental health system and any variation in these experiences across services.

The MHCC's regular and planned meetings with services to discuss the themes from the complaint data reports were disrupted by the COVID-19 pandemic. However, we will continue to meet with mental health services about themes from these reports in the coming year.

Moving towards reporting service-level data

Presently, service-level complaint data is made available to individual services through the individual service provider reports and is not shared publicly. However, publicly sharing service-level complaint data is an important way to increase transparency about the nature of people's experiences within the mental health system, and to support consumers, carers and services to identify opportunities for service improvement.

The MHCC has not yet published service-level complaint data for two reasons. Firstly, the recording and reporting of complaints by services varies considerably. Therefore, as a first step to making more data publicly available and encouraging stronger recording and reporting of complaints, we intend to work to share service-level data comparing complaint rates per 1,000 consumers for complaints made directly to individual services with complaints made to the MHCC. This data will provide a sense of how well the service identifies, records and addresses complaints at the local level.

The second and more significant reason that the MHCC has not yet published service-level complaint data is that complaint data alone is not a reliable indicator of service quality. Complaints represent only a portion of people's experiences and numbers of complaints alone do not represent service quality. For example, 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 could either indicate issues with the recording of complaints or the service's approach to complaints, or a high level of satisfaction with the service. Sharing complaint data without further context has the risk of incorrect conclusions being drawn about the nature of people's experiences and the quality of individual services.

The MHCC will continue to explore whether other sources of data, including incident reporting data and results from the national Your Experience of Service (YES) and the Carer Experience of Service (CES) surveys could be shared alongside service-level complaint data. This would provide a more complete picture of people's experiences, and enable the data to be used by consumers, families, carers and services to identify key areas for attention and to drive service improvements.

16 The provision of these reports were enabled by amendments to the Act and its regulations in October 2019 and February 2020, which provide for the MHCC to provide information on quality, safety and other issues arising out of complaints to the Secretary of the DHHS and prescribed bodies.

Current data

Observations

Overall, numbers of complaints reported by designated mental health services were proportionally similar in July–December 2019 compared to 2018–19. As in previous reporting periods we continued to observe significant issues in relation to data collection by services. 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 in issues captured and a lack of outcome data reported. We 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.

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. However, it appears from the July–December 2019 data that services have improved their identification of complaints made first to the MHCC compared to previous years, allowing us to exclude these complaints.

Overview of complaints reported by services 1 July 2019 to 31 December 2019

This overview provides a comparative analysis of data from complaints made to designated mental health services and to the MHCC for the period 1 July 2019 to 31 December 2019. It compares numbers, service types, issues and sources of complaints. We have not yet requested January–June 2020 complaint data in recognition of the impact of COVID-19 on services.

Analysis of complaint outcomes will be included in the statewide report on complaints trends to be published in 2020–21. We note that reporting on complaints outcomes has historically been low (47 per cent of all reported complaints in 2018–19). We will continue to seek to address this with services, as this forms part of the MHCC's data requests and is important to understand variation in how complaints are resolved and identify areas for improvement.

All 21 designated Victorian mental health services provided complaint data for July–December 2019 to the MHCC, consistent with the 100 per cent compliance rate observed in 2018–19. As noted above, complaint data for January–June 2020 was not sought from services due to the impact of COVID-19. This data will be sought at a later date to inform individual service provider reports for 2017–18 to 2019–20.

Designated mental health services reported a total of 767 in-scope[17] complaints over July–December 2019, very similar to the total number of complaints reported by services from July–December 2018 (764). The MHCC hopes to see a continued increase in the 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.

Complaints reported by services compared to complaints made to the MHCC

The total of 767 in-scope complaints that were raised directly with designated mental health services from July–December 2019 was lower than the 791 in-scope complaints[18] made to the MHCC (MHCC complaints) about designated mental health services during this period. While this is marginally higher than the number of complaints reported by services for the same period in 2018, the number of complaints reported by services continues to be lower than would be expected considering the total number of consumers accessing services from designated mental health services, which in July–December 2019 was 54,679 consumers.[19]

We would expect to see this trend reversed 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.

17 Complaints that are about people's experiences with a Victorian public mental health service.

18 Out-of-scope complaints made to the MHCC have been excluded to enable direct comparison with complaints made directly to services. The MHCC received 807 complaints in total between July and December 2019 about designated mental health services, of which 16 were out of scope. The main reason that complaints were out of scope was that they related to issues arising prior to July 2013 or the complaint did not identify a consumer.

19 Data provided by VAHI on registered consumers of designated mental health services.

Complaints per 1,000 consumers

Comparing the number of complaints made against 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 VAHI, there were 54,679 consumers of designated mental health services between 1 July 2019 and 31 December 2019.[20]

Using this indicative data, there were 14.0 complaints made per 1,000 consumers of designated mental health services, slightly lower than the rate of 14.5 complaints per 1,000 consumers raised directly with the MHCC. Due to the difference in time periods, rates of complaints made to services and the MHCC for July–December 2019 are not directly comparable with the rates of complaints published in the 2018–19 annual report.

Our meetings with services about their complaint data include discussion about the number of complaints per 1,000 consumers compared to similar services and sector averages, and ways of interpreting the data and apparent trends.

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 made between July and December 2019 related to treatment (raised in 46 per cent of complaints), conduct and behaviour of staff or co-consumers (27 per cent), facilities (22 per cent) and communication (19 per cent). This is similar to themes observed in 2018–19. Themes in complaints made to services from July to December 2019 are described further below.

Treatment

The most common issues raised about treatment related to responsiveness of staff, including inadequate consideration of the views and preferences of consumers, both compulsory and voluntary, as well as of the views of family members or carers. Complaints were also made about suboptimal treatment, including leave concerns, disagreement with treatment orders and inadequate treatment options or planning, as well as unsafe or premature discharge.

Conduct and behaviour

Complaints about conduct and behaviour were most commonly about perceived rudeness by staff, in particular a lack of respect or courtesy. Other complaints made were about alleged threats, bullying or harassment by staff or other consumers.

Facilities

Complaints about facilities were most commonly about lost, stolen or damaged property, lack of satisfaction with accommodation or lack of cleanliness.

Communication

Issues reported about communication were most commonly about the provision of inadequate, incomplete or misleading information to consumers or family members and/or carers, or inadequate communication with families and/or carers.

20 See footnote above. These consumer numbers provided by VAHI should be treated as indicative numbers only as this data was still subject to further checking and validation at the time of writing this report.

By contrast, 68 per cent of complaints made to the MHCC between July and December 2019 included concerns about treatment issues, with communication issues the next most common area of concern (raised in 31 per cent of complaints), followed by concerns about behaviour or conduct (25 per cent) and medication (25 per cent).

As in previous years, the broad gap between complaints to the MHCC and made directly to services about treatment issues continues to be concerning, as it is expected that services would encourage and support people to raise any concerns about their treatment 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 concern directly with services. There were also fewer complaints reported by services about sexual safety breaches by consumers than there were complaints to the MHCC about these. These questions continue to inform our education and engagement work with services, and our role in promoting service and systemic improvements.

The MHCC continues to observe consistent themes of concerns with 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 are embedded into all aspects of treatment and care, particularly how people are supported to make decisions about their assessment, treatment and recovery.

Service program types

Where the service program type was able to be identified, complaints reported by designated mental health services for July to December 2019 were most commonly about adult mental health services including forensic mental health services (77 per cent), similar to the 79 per cent of reported complaints about these services in 2018–19.[21]

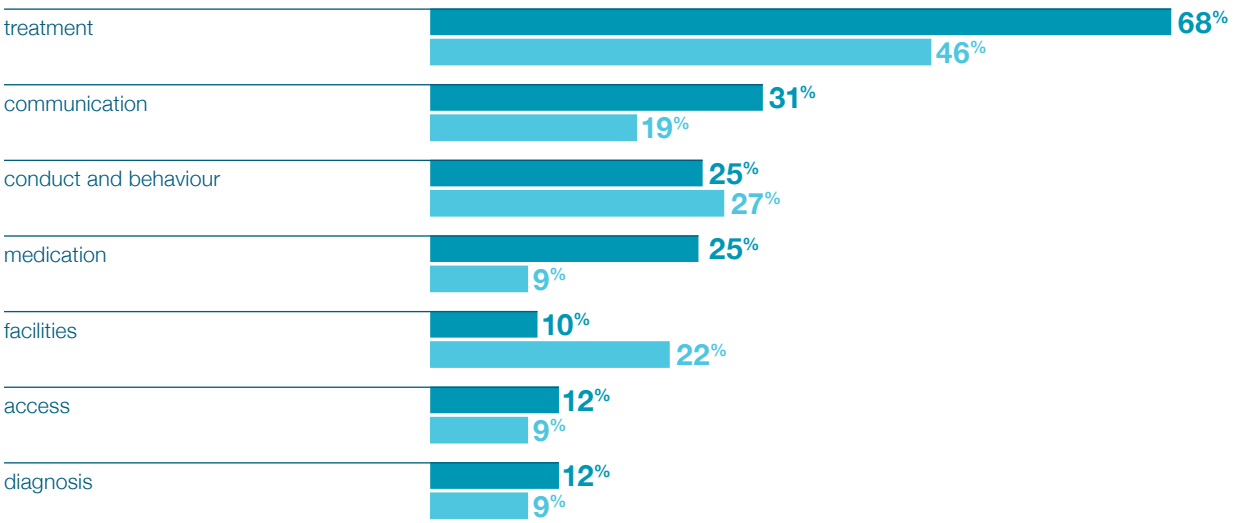
Ten per cent of complaints were about child and youth mental health services (CYMHS) or child and adolescent mental health services (CAMHS), similar to the eight per cent of these in all reported complaints in 2018–19.

Complaints reported about aged persons mental health services accounted for five per cent of complaints, similar to the six per cent of all reported complaints in 2018–19.

Figure 17

Issues raised in complaints to the MHCC compared to services

This compares the issues people raised in complaints to the MHCC with issues raised in complaints they made directly to mental health services. People were more likely to contact the MHCC than services about complaints regarding treatment, communication, and medication. People were more likely to contact services with concerns about facilities (e.g. accommodation, food, lost property, etc.).



21 Percentages of complaints about service program types for 2018–19 were recalculated since the 2018–19 annual report to exclude MHCSSs and enable comparison with July–December 2019 complaints about designated mental health services only.

Complaints about programs that provide services to people of all ages, including triage and emergency departments, accounted for eight per cent of complaints, similar to the seven per cent of all reported complaints in 2018–19.

For complaints reported by designated mental health services for July to December 2019, reported complaints were predominantly about inpatient services (59 per cent), with 28 per cent about community-based services, 11 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).

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 66 per cent of reported complaints to designated mental health services between July and December 2019, compared to 73 per cent to the MHCC. Family members or carers made 29 per cent of reported complaints compared to 24 per cent of MHCC complaints, which was consistent with 2018–19. Five per cent of complaints were made by friends, advocates or legal representatives, or other service providers, while for an additional one per cent of complaints the source of the complaint was unknown.

Our priorities

Data about complaints made to mental health services is an essential source of information for the MHCC's 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, DHHS, the OCP, SCV and VAHI to address the critical need to improve complaints reporting systems and associated data reporting 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 VAHI to enable clearer identification of issues and areas requiring safeguarding and service improvement actions.

Figure 18

Who made complaints to services and the MHCC

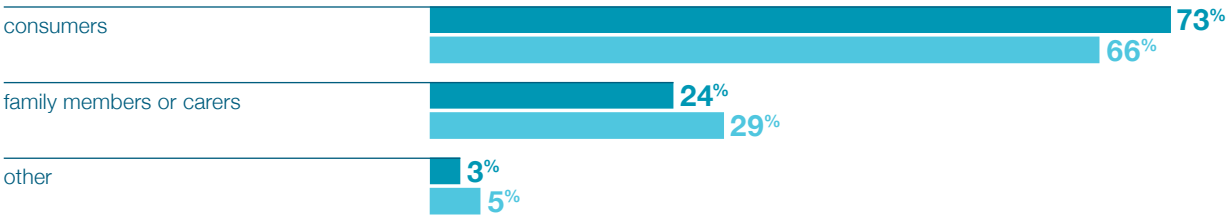
MHCC

Base: in-scope complaints made to the MHCC about designated mental health services July–December 2019 (n=791)

Services

Base: in-scope complaints made to designated mental health services July–December 2019 (n=767)

This compares who made complaints to services with who made complaints to the MHCC. Consumers made 66 per cent of the 767 complaints made to services, carers made 29 percent, and 5 per cent were made by others including lawyers, advocates and staff. Consumers made 73 per cent of the 791 complaints made to the MHCC, carers made 24 per cent, and 3 per cent were made by others.



Example complaint: family violence

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

Susan's complaint

Summary

Susan is a young woman living alone after separating from her husband. She raised concerns that her community mental health service planned to discuss her treatment and care with her former husband, Andrew, after she had specifically asked they not do so because of his previous and ongoing psychological and emotional abuse. The experiences Susan described constituted family violence.

What Susan told us

Susan told us that she had left her husband two years ago and since then Andrew had threatened to prevent her from seeing her child and told her he intended to make her life difficult. Susan had told the mental health service about his threats and asked that he not be involved in her treatment and care. She had also advised the service that her sister was her carer and could be involved in discussions about her treatment and care.

Despite this, the service made the decision to invite Susan's former husband to a meeting to discuss her treatment because he had advised the service he was her carer and they were co-parenting their child. The service advised Susan that they felt they needed his participation. Susan felt the meeting's purpose was unclear, would not be helpful and that Andrew had contributed to her mental health problems. She was concerned that the service did not regard her as a victim of family violence.

Although she had the choice not to attend the meeting, Susan felt she had to go as she did not want the discussion to occur without her input and she wanted to know what the service was telling Andrew about her.

How the mental health principles applied to the complaint

The *Mental Health Act 2014* (the 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 section 11(1) of the Act.

The principles most relevant to Susan's complaint are:

e Promote rights, dignity and autonomy

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

This principle needs to be interpreted in conjunction with the *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the obligations on mental health services to protect people from family violence.

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.

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 principles mean for Susan?

Family violence is a fundamental violation of a person's human rights and mental health services have a responsibility to take steps to protect victims from further incidents.

In order to maintain Susan's rights, dignity and respect, and to meet her individual needs, a meeting with an alleged perpetrator of family violence, whatever the purpose, should not take place against her expressed wishes.

Susan had the right to be heard and for her preferences to be followed wherever possible. This included respecting her preferences about who she chose to have involved in her treatment and care. Even if the service considered it important to hear from her former husband, this could have been done in other ways.

Our involvement

Susan called the MHCC shortly before the proposed meeting, wanting it not to proceed. We escalated this immediately to the Clinical Director of the service, but the meeting proceeded in spite of Susan's concerns being known by the service.

Susan contacted us after the meeting, distressed and traumatised by the event. She told us that her former husband had been verbally abusive at the meeting, causing her to leave part way through with her support person. She described how he had found her after the meeting and continued to harass her, adding to her distress and trauma.

We assessed that the service's actions raised serious questions about their obligations to address the risk of family violence for Susan and to comply with the *Chief Psychiatrist's guideline and practice resource: family violence* (2017). We assisted Susan to put her concerns in writing and requested a formal response from the service to explain their actions and their insistence on the meeting.

The service advised that they had assessed that the meeting was needed to determine the best way to communicate with both parties given Andrew had claimed he was a carer. The service confirmed that no clinical information had been provided to him but acknowledged the distress the meeting had caused Susan. We identified serious issues in the service's lack of recognition of Susan as being a victim of family violence, and that the meeting had exposed her to a further incident of violence.

We assessed the response from the service against the requirements of the *Chief Psychiatrist's guideline* and the mental health principles, and in consultation with Susan. We identified ways in which the service's approach had not met the requirements of the family violence guideline or demonstrated an understanding of the service's obligation to proactively respond to Susan's needs as a victim of family violence. Susan was also very unhappy with the service's response and felt that staff did not understand the nature of family violence. We outlined these issues and concerns to the service and discussed ways in which these could be addressed.

Outcomes

We requested a face-to-face meeting with senior staff of the service so that Susan could provide feedback about her experiences and the service could outline the actions they had taken in response to her complaint. The facilitated meeting was chaired by MHCC staff, who gave Susan the opportunity to express her distress and the impacts of the service's actions. The service staff acknowledged the trauma and distress experienced by Susan and their failure to recognise and address the risks of family violence. They also provided an apology for her experience and outlined actions they had taken to implement new systems and practices to address family violence. These actions included training for clinical staff in identifying and understanding family violence and the employment of a part-time family violence worker.

After the meeting Susan told us that she was glad she participated in this meeting and felt the service had listened to her concerns. She was pleased to receive an apology for her experience. While she is still upset by what happened to her, she felt that the service's actions to address family violence were constructive and should help others in future.

In closing the complaint, the MHCC recognised that the service had taken actions to improve their practices in respect to family violence but also made recommendations to the service to build on these improvements. The MHCC's recommendations included that:

- the planned training include the requirements and guidance of the *Chief Psychiatrist's guideline*, particularly the guidance that where family violence is occurring, clinicians need to respect the victim survivor's wishes about the involvement of those family members
- the service review their practice about how the status of carers is determined, noting that Susan had advised the service of someone, her sister, who could be involved in her treatment and care.

Susan's complaint highlighted the importance of mental health staff being skilled in recognising, understanding, and responding effectively to family violence, and the role of services in upholding victim survivors' right to be safe and protected from further violence.

Promoting service and system improvement

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

When the MHCC makes recommendations under the *Mental Health Act 2014*, services are expected to commit to the actions necessary to achieve the recommended change. We assess the response and request further information or provide 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.

Our role and approach

The MHCC has encouraged us to engage with complaints and feedback more than we might otherwise do through our internal complaints system.

— Service provider

MHCC [staff] are helpful and accessible and willing to have a broad discussion to nut out an issue.

— Service provider

The 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 can invite and accept a formal undertaking from a mental health service to take specific actions to achieve required changes in practice and service improvements.
(See discussion in ‘Safeguarding people’s rights through complaint resolution’ on page 18.)

Our office identifies safety and quality issues arising from people’s experiences of mental health services to make recommendations that will address risks and ensure people’s rights are upheld. The views and voices of consumers and families, carers or other support people are critical in informing recommendations that will improve the quality and safety of mental health services, and the way people experience these services.

In 2019–20 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 which were facilitated by our office as part of the resolution process. The MHCC also makes formal recommendations for service improvements as an outcome of safety and quality issues identified in complaints, including recommendations to individual services and systemic recommendations to the Department of Health and Human Services. The MHCC, Department, Chief Psychiatrist and Chief Mental Health Nurse continue to work closely together to respond to these systemic issues, to improve the quality and safety of mental health services for all consumers, families and carers.

Service improvements and recommendations to services

The staff are always courteous and thorough when communicating about a complaint as well as in their responses to complaints and resolutions.

— Service provider

In 2019–20 the MHCC recorded 148 improvements made by services as outcomes of 68 complaints and investigations, significantly higher than the 88 service improvements recorded in 2018–19. Of these improvements, 118 related to complaint resolution and 30 were recorded as a result of MHCC investigations.

Of the 148 service improvements, 53 related to changes to service practices, 47 related to training and feedback provided to staff, 33 related to changes to policies and procedures, eight related to infrastructure changes and seven related to other kinds of improvements (see Figure 19).

In 2019–20, the MHCC also made 121 formal recommendations for service improvements, mostly to review practices, policies and procedures. Of these, 108 arose through complaint resolution, and 13 through investigations. 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 2020–21.

Figure 19

Service improvements and recommendations

This shows a list of actions to improve services in 2019–20 that arose from complaints made by consumers, carers and others. This includes actions taken by services (service improvements) and actions recommended and encouraged by the MHCC (recommendations and undertakings).

276

actions to improve services, including:

121 recommendations to mental health service providers

3 systemic recommendations to the Chief Psychiatrist, DHHS or Safer Care Victoria

148

service improvements as outcomes of complaints:

53 changes to service practices

47 training/feedback to staff

33 changes to policies/procedures

8 changes to infrastructure

7 other improvements

4

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

What changes were made because people made a complaint?

I think the MHCC has provided a strong voice for the consumer who has been affected and this is a good thing. It has assisted our service to be more person-centred.

— Service provider

Some examples of the improvements made in 2019–20 as a result of complaints are outlined below, grouped by the mental health principle of the Act they most strongly relate to:

a Provide least restrictive treatment

- developing new strategies for managing conflict around administration of medication, to support the involvement of the consumer and use the least restrictive intervention possible
- reviewing policies and procedures, and providing staff training on support and debriefing for consumers following the use of restrictive interventions
- commitment to cease using forms of restraint which are not recommended in the Chief Psychiatrist's guideline
- guidance to staff to ensure that any decisions made in the inpatient unit have a sound rationale and are clearly communicated to consumers.

b Promote recovery

- development of a new model of care in an aged person's mental health service to respond to the complexity and acuity of consumers' needs
- improving connections with external advocacy services to ensure consumers can access advocacy even when face-to-face services are not available
- improving access to services and supports such as activity rooms, music therapy, exercise physiology and dietetics
- changing the use of rooms within a unit to make a room available for family visits that do not require families to enter the acute inpatient unit
- making peer support and debriefing available within the emergency department
- seeking lived experience-led training for staff in techniques, including motivational interviewing and health coaching
- implementing therapeutic engagement training for staff.

c Ensure supported decision making

- reviewing policies and procedures that guide the development of treatment plans, to ensure consumers are involved in discussions about their preferences.

e Promote rights, dignity and autonomy

- improvements across several services to ensure Statements of Rights are provided at admission, readily available in common areas and/or individual rooms of the inpatient unit and that community teams are supplied with Statements of Rights. Improvements also included improved processes for discussing rights at regular intervals
- creating flexibility in the use of restrictive interventions to support people to access toilet facilities in a way that respects their dignity
- changes to improve and respect consumers' privacy, including changing the rooms where clinical discussions are held, and changing the location of information boards
- increasing the availability of food during COVID-19.

f Recognise and respond to medical needs

- ensuring that where a person has needs in addition to their mental health needs, these needs, and the environment where they can best be met, are an integral part of treatment planning
- improvements to how a service supports consumers with an eating disorder, including development of a shared care protocol, as well as specialised training in working with consumers with eating disorders being provided to staff across various areas of the health service, including mental health, alcohol and drug services, paediatrics, and the emergency department.

g Recognise and respond to individual needs

- making improvements to sexual safety in an inpatient unit, including improving orientation processes, to clarify which areas of the unit are women-only, implementing new daily safety planning processes, improving access to wrist bands to ensure women can access women only areas of an inpatient unit, and reminding staff that it is an expectation that requests for bedroom doors to be locked will be respected and adhered to
- training for staff on family violence, and the employment of a family violence worker
- training for staff on working with people with a trauma history, implementation of *Safewards*, approaches to suicide assessment and prevention, proactive interventions, and violence and aggression training.

j Protect children and young people

- improving referral processes in a service for children and young persons to ensure robust discharge planning and management.

k Involve carers

- education and training provided on working with families and carers
- ensuring families and carers are included in discussions and decisions about treatment and care, as outlined in the principles of the *Mental Health Act 2014*.

l Recognise, respect and support carers

- implementation of clinical practice guidance on supporting bereaved families
- a service taking steps to better acknowledge the lived experiences of carers and family members when communicating with them.

Improvements were also made to approaches to complaints, and management of risks, including:

- creation of a mental health complaints officer position at one service where this did not previously exist, and clarifying complaint management processes
- removal of ligature points within a service, implementation of a clinical practice guideline on managing ligature points in a mental health inpatient setting, including regular review of potential ligature points
- improving risk assessment and management processes.

Recommendations to the Secretary of the DHHS (2019–20)

In 2019–20 the MHCC made three recommendations to the Secretary of the DHHS as a result of systemic issues identified through complaints and investigations. Some of these recommendations were also jointly made to the Chief Psychiatrist and Safer Care Victoria as outlined below. All of these recommendations related to significant issues of rights, safety and quality identified in complaints about traumatic and adverse events experienced by consumers.

1. Suicide attempts in mental health inpatient units

The MHCC made a recommendation jointly to the Secretary of the DHHS, the Chief Psychiatrist and Safer Care Victoria to consider specific issues identified in two complaints about suicide attempts in mental health inpatient units. These issues included specific concerns about the adequacy of engagement with consumers and carers, risk assessment and management, safety planning following a suicide attempt, the types of bedding provided to consumers, and review processes.

An overview of one complaint where serious issues arose about the management and review of suicide attempts within an inpatient unit is included in this report (page 36).

The MHCC recommended that the Secretary of the DHHS, the Chief Psychiatrist and Safer Care Victoria consider, as applicable to their role and functions, the issues as identified in these complaints to:

a inform future sentinel event reviews of suicide attempts in mental health inpatient units, including:
  – the use of bedding, and in particular the provision of sheets to consumers who are at high risk of attempted suicide
  – the adequacy of reviews undertaken by mental health services following a suicide attempt in a mental health inpatient unit
b assess the need for specific guidance to mental health services about these issues.

2. Prolonged use of mechanical restraint in emergency departments

The MHCC made a recommendation to the Secretary of the DHHS and the Chief Psychiatrist in relation to systemic issues identified from complaints to the MHCC about the prolonged use of mechanical restraint in emergency departments. While a range of initiatives have been taken by the DHHS, the Chief Psychiatrist and services to address the use of restrictive interventions in emergency departments, complaints to the MHCC over several years indicate that there continue to be systemic issues about compliance with:

– the provisions of the Act in relation to the use of mechanical restraint in emergency departments
– the *Charter of Human Rights and Responsibilities Act 2006*
– the *Chief Psychiatrist's guideline: Restrictive interventions in designated mental health services*.

These issues have been the subject of discussions and shared concern in the MHCC's regular meetings with the Secretary, DHHS Mental Health Branch and the Chief Psychiatrist and Chief Mental Health Nurse. The adverse experiences of mental health consumers in emergency departments were also highlighted in the MHCC's submission to the Royal Commission into Victoria's Mental Health System and the Commissioner's witness statement to it.

The MHCC undertook a number of detailed assessments and investigations of complaints about mechanical restraint in emergency departments which have provided deeper insights into the nature of the systemic issues and causes of these adverse events (see 'Safeguarding rights and resolving complaints' page 39 and complaint example page 40). The key themes and systemic issues identified in these complaints included:

– insufficient evidence of less restrictive alternatives being tried or considered before a person is restrained
– the use of prolonged mechanical restraint (periods of 8–20 hours) without evidence of an assessment of whether restraint continued to be necessary to prevent imminent and serious harm or to administer treatment during that period
– lack of, or inadequate, oversight by the authorised psychiatrist or delegate including:
  – the authorised psychiatrist is often not notified of the use of restraint
  – where medical examinations required by the Act are undertaken, these are usually performed by registrars and not psychiatrists, and often there is no evidence of an assessment about whether the criteria for continuing restraint are met
  – when psychiatrists undertake an examination (often the next day) the decision is frequently made that restraint is no longer necessary
  – failure to escalate concerns about a person's presentation to the on-call psychiatrist
– a failure by medical practitioners and the senior registered nurse on duty to understand their obligation under s 109 of the Act to immediately release a person if they are satisfied the continued use of restraint is no longer necessary, and not to wait until a review by the authorised psychiatrist
– a failure by nursing staff who undertake clinical reviews to seek approval to release a person from restraint if they have observed that restraint may no longer be necessary (e.g. where a person is calm and settled)
– confusion about whether emergency department staff or mental health staff have primary responsibility for review of the person, and failure by emergency mental health clinicians to take an active role in the care and treatment of consumers restrained under the Act
– examples where the plan was to continue to restrain the person until a bed in an inpatient unit could be found, or until a review by a psychiatrist, with no evidence of steps taken to expedite these outcomes – resulting in the person being mechanically restrained until the next morning
– use of incorrect forms or failure to complete correct forms (e.g. emergency department form used rather than MHA140 form, or MHA140 form used and Part B not completed or only partly completed)
– frequent failure to report the use of restraint to the Chief Psychiatrist
– lack of, or inadequate, evidence of post-restrictive intervention debriefing or experience of care review as outlined in the Chief Psychiatrist's guideline
– evidence of a desensitisation on the part of both emergency department and mental health staff to the gravity of the impact of the use of mechanical restraint on consumers.

Accordingly, the MHCC recommended that the Secretary of the DHHS and the Chief Psychiatrist:

- note the systemic issues identified in relation to the use of mechanical restraint in emergency departments, and in particular issues raised about compliance with the requirements, safeguards, and protections in the Act for the lawful use of mechanical restraint
- review how compliance with the Act in emergency departments can be strengthened and enforced, including consideration of:
  - the need for specific training for medical and nursing staff who work in emergency departments where a person can be taken and detained for compulsory assessment or treatment in accordance with the Act
  - the need for a written direction or Clinical Practice Advisory Notice in relation to the responsibilities of the authorised psychiatrist and the role of mental health/consultation liaison staff
  - the option of a clinical practice audit by the Chief Psychiatrist pursuant to s 134 of the Act.

The MHCC is confident that these systemic issues will be addressed in the response from the Secretary of the DHHS, the work being undertaken by the offices of the Chief Psychiatrist and Chief Mental Health Nurse including the work described on page 59 of this report, and in the final report of the Royal Commission into Victoria's Mental Health System.

3. Issues that arise when emergency departments are not part of a designated mental health service

The MHCC also made a recommendation to the DHHS about issues that arise where mental health services at a hospital are provided by a different service than the service that operates the emergency department and when the mental health services are provided in the emergency department by a different legal entity. This is the case at two major hospitals in metropolitan Melbourne.

Complaints to the MHCC have shown that this arrangement creates additional challenges to clinical governance and decision-making processes between emergency department and mental health staff, which impact on the effective and timely treatment and care of consumers. It also creates gaps in the legislative and safeguarding framework and uncertainty about which complaints body has jurisdiction to manage complaints arising in these situations.

Accordingly, the MHCC recommended that the Secretary of the DHHS:

- review the arrangements that exist whereby health services that are not designated mental health services receive and treat consumers subject to Compulsory Treatment Orders under the Act having regard to the legislative and safeguarding issues that arise
- clarify the jurisdiction of the MHCC to deal with complaints about health services that are not designated mental health services where they provide treatment and care to consumers subject to a Compulsory Treatment Order under the Act.

These safeguarding and legislative issues were also raised in the Commissioner's witness statement to the Royal Commission into Victoria's Mental Health System.

Reporting on recommendations made in previous years

We continue to work closely with the DHHS regarding recommendations made in previous years. In 2019–20 we continued regular governance meetings with the DHHS to discuss and monitor responses to our recommendations.

Sexual safety recommendations

The MHCC continues to work with the DHHS and Chief Psychiatrist to monitor progress against the recommendations of the MHCC's sexual safety project report, *The Right to be Safe – Ensuring sexual safety in acute mental health inpatient units*. We acknowledge the commitment of the DHHS and the Chief Psychiatrist's Sexual Safety Committee to progressing this work, and continue to highlight the importance of an overarching strategy to bring together the work that is underway to ensure sexual safety in mental health acute inpatient units. We are pleased that sexual safety continues to be a high priority for the DHHS and the work of the Chief Psychiatrist. Significant work has been undertaken in response to recommendations from *The Right to be Safe* report, such as the completed infrastructure audit of inpatient units to achieve minimum safety standards across services, and in other areas as noted in the DHHS response on page 59.

In 2018–19, the MHCC requested advice and updates from Victorian mental health services about how they were responding to the recommendations of *The Right to be Safe* report. In 2019–20 we published a summary of those responses, noting key themes and areas for further improvement. We discuss these themes with the DHHS, the Chief Psychiatrist and services in our usual regular meetings.

Responses from some services showed that they have made significant improvements to their processes and culture in respect to sexual safety. These changes help to ensure that people receiving inpatient treatment are, and feel, sexually safe. However, not all services reported this level of improvement. The MHCC continues to work with individual services where complaints are made about sexual safety, to highlight and recommend areas for improvement, and with the Chief Psychiatrist on the themes identified from these complaints.

Update on MHCC recommendations to DHHS

The department continues to successfully work in partnership with the MHCC to improve the experience of care for mental health consumers and carers.

The COVID-19 pandemic has posed significant challenges for the mental health system, consumers and carers in the latter half of the 2019–20 year. Similarly, the department, including the Office of the Chief Psychiatrist (OCP), has experienced an unprecedented increase in demand. Despite this, significant work has progressed.

The Chief Mental Health Nurse and Chief Psychiatrist continue to lead the department's workplan to improve sexual safety in Victoria's mental health services, in line with the directions of the MHCC's *The Right to be Safe*. report. This includes:

- overseeing revision of the Chief Psychiatrist's guideline for sexual safety in acute mental health inpatient units
- co-designing the department's service guideline on gender sensitivity and safety with consumer and carer representatives
- reporting back to mental health services on statewide data for sexual safety notifications, including high-level analysis of reported incidents.

The Chief Psychiatrist's statutory committee on restrictive interventions has committed to a program of work to support the elimination of restrictive interventions. This approach is consistent with the directions of the national Safety and Quality Partnership Standing Committee.

The OCP continues to refine and better understand data on restrictive interventions in Emergency Departments (EDs). The office has maintained engagement with the EDs clinical network to raise these issues and to improve system-wide understanding of the complexities of pathways for consumers accessing mental health services via hospital EDs.

Safewards Victoria has been fully implemented across all mental health units in Victoria. A trial of Safewards Victoria in EDs has been underway during 2019–20, with results expected in late 2020. This represents the first trial of Safewards in the ED globally.

The *Mental Health Intensive Care* framework was released in early 2020 and represents a shift in understanding of engagement when people are at their most vulnerable, moving from a culture of control to a culture of care.

The *Chief Psychiatrist's guideline* on risk assessment and safety planning in mental health inpatient services was finalised in early 2020; however, the formal release of the guideline has been postponed in the context of the COVID-19 pandemic.

The department has established a Complex Care Needs Advisory Panel, to improve outcomes for persons with complex needs who pose an unacceptable risk of harm to others. Parallel work includes the development of policy, processes and services that would enhance support for this consumer group, in collaboration with sector experts.

Contributions to consultations, projects and advisory groups

The MHCC takes 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 2019–20 we provided input into key projects and consultations including:

National

- Australian Commission on Safety and Quality in Health Care – Open Disclosure Implementation Consultation
- Australian Commission on Safety and Quality in Health Care – Consultation on National Safety and Quality Digital Mental Health Standards
- National Mental Health Commission Project – National Peer Workforce Development Guidelines
- National Mental Health Commission 'Vision 2030' Consultation
- National Mental Health & Wellbeing Pandemic Response – consultations with Mental Health Commissioners Group
- National Stigma Report Card Project by SANE Australia – Panel participant
- Productivity Commission Mental Health Inquiry – MHCC hosted consultations
- University of Melbourne Research Project – *Informing a national strategy to reduce stigma and discrimination towards people with mental illness* – the MISRed project

Victorian

- Chief Mental Health Nurse's project work on sexual safety and responses to *The Right to be Safe* recommendations
- DHHS Intersex Resources Project
- DHHS Restrictive Practices Statutory and Regulatory Authorities Roundtable
- Disability Worker Regulation Scheme – Proposed Regulations Consultation
- Health Legislation Amendment and Repeal Bill 2019 – Consultation on consequential amendments to *Mental Health Act 2014*
- Inner Melbourne Community Legal – PACER Project
- Victorian LGBTIQ Strategy Consultation
- Victorian Mental Health Interprofessional Leadership Network's sexual safety guidelines project undertaken for the Chief Psychiatrist.

Contributions to the Royal Commission into Victoria's Mental Health System

The MHCC has actively contributed to the Royal Commission into Victoria's Mental Health System, including through a detailed submission made in July 2019. In 2019–20, in response to a Notice to Produce, the MHCC provided the Royal Commission with:

- copies of local complaints reports that outline themes and trends in complaints across each Victorian area mental health service[22]
- a summary of service responses to the recommendations made in our sexual safety report, *The Right to be Safe*
- an analysis of sexual safety complaints received in 2017–18 and 2018–19.

The Commissioner also prepared a detailed witness statement that has been published on the Royal Commission's website and has received a further Notice to Produce.

22 Reports were not completed for MHCSS due to the very low number of complaints received by and reported to the MHCC.

Advisory groups

The MHCC also participated in six key advisory and reference groups to support related areas of work. These are the:

- DHHS Progress Measures Working Group
- DHHS Lived Experience Advisory Group (Associate member)
- Office of the Chief Psychiatrist Sexual Safety Committee
- Safer Care Victoria Mental Health Clinical Network Insight Subcommittee
- Second Psychiatric Opinion Service Advisory Group
- Victorian Ombudsman Optional Protocol to the Convention against Torture (OPCAT) Investigation Advisory Group.

As a member of the Victorian Ombudsman OPCAT Investigation Advisory Group, the MHCC directly contributed to the report OPCAT in *Victoria: A thematic investigation of practices related to solitary confinement of children and young people* (Victorian Ombudsman Sept 2019). Through participating as a mental health advisor as part of the inspection team as well as the Advisory Group, the MHCC highlighted the pressing need for appropriate mental health treatment for young people in youth justice centres and prisons assessed as being at high suicidal risk and the extremely harmful impacts of the use of solitary confinement. The insights gained through participating in this investigation were included in the MHCC's submission to the Royal Commission into Victoria's Mental Health System.

The MHCC has also committed to contributing to the Chief Psychiatrist's Trauma Informed Care and Practice Expert Advisory Group. In addition, the MHCC supported the Victorian Premier's Volunteer Champions Awards 2019 and the Victorian Public Healthcare Awards 2019 by participating as a member of the judging panels. Further information about our contributions is provided in Appendix 2 (see page 76).

Submissions and reports

In 2019–20 we provided formal feedback for the:

- Ambulance Victoria's Accessibility Action Plan
- DHHS Mental Health Care COVID-19 response – Inpatient consumer pathways
- DHHS Victorian Nurse Practitioners Prescribing Consultation
- Disability Worker Regulation Scheme – Proposed Regulations
- National Mental Health & Wellbeing Pandemic Response – contributions to draft paper prepared by National Mental Health Commission for the National Cabinet
- Productivity Commission Mental Health Inquiry – Response to Draft Report (Individual MHCC response and Joint Mental Health Commissioners' response)
- Royal Commission into Victoria's Mental Health System – Commissioner's Witness Statement
- Royal Commission into Victoria's Mental Health System – Submission
- Safer Care Victoria clinical guidelines for *Caring for People Displaying Acute Behavioural Disturbance in Emergency Settings*
- Safer Care Victoria Mental Health Clinical Network – *Improving How Consumer Completed Measures are Used in Clinical Mental Health Services*.

Participation in national meetings

The MHCC is a member of the Health Complaints and Disability Commissioners' group that addresses common issues across jurisdictions, including approaches to complaints about mental health services and psycho-social supports funded under the National Disability Insurance Scheme (NDIS). We are also a member of the national 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. The MHCC looks forward to continuing to contribute to the Royal Commission into Victoria's Mental Health System and to supporting implementation of the broad-ranging systemic reforms that will arise from its interim and final reports.

Education and engagement

Under the *Mental Health Act 2014* (the Act), the MHCC must ensure the process for making a complaint about public mental health services is available to all Victorians. We work to ensure consumers, families and carers 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 promotes awareness about the Act's mental health principles, and the role and functions of the MHCC in safeguarding human rights.

In addition, the Act requires the MHCC to educate public mental health services about their responsibilities and requirements when responding to complaints. We engage with the mental health sector and work directly with services to promote cultures in which people are supported to speak up about their concerns, and where complaints are seen as opportunities for service improvement. Submissions, consultations and contributions to projects also give the MHCC the chance to contribute to broader systemic change.

In 2019–20 the MHCC engaged with the mental health sector in a variety of ways, including through presentations, education and training sessions, targeted engagement activities with consumer and carer groups, and participating in sector and stakeholder events. These education and engagement activities directly reached 17,648 people. A detailed list of the MHCC's education and engagement activities is in Appendix 2.

Consumer and carer engagement

The MHCC raises the profile of mental health in a positive way.

— Consumer

In 2019–20, we undertook 13 consumer and carer engagement activities, reaching over 350 people through direct engagements, and thousands more through broad reach activities such as targeted radio interviews, blogs and participating in community events.

The MHCC is driven by lived experience in everything we do. It is therefore important for us to have a strong relationship with the Victorian Mental Illness Awareness Council (VMIAC), the peak organisation for people with a lived experience of mental health challenges. In 2019–20 MHCC staff participated in VMIAC meetings and events and shared its resources widely, including on social media. We also attended, and held an information stall, at VMIAC's *Listen Up Listen Louder* conference, which put lived experience front and centre of discussions about mental health reform. In February 2020, the VMIAC CEO and lived experience leader Maggie Toko took a leave of absence to join the MHCC as Deputy Commissioner, overseeing many aspects of our work. This has furthered our awareness of issues faced by mental health consumers and our ability to meaningfully engage with them.

The MHCC also engages with Tandem, the Victorian peak body representing families and friends supporting people living with mental health issues. In October 2019 we attended, and held an information stall, at the Tandem Carers Conference: *Working in Tandem for a compassionate mental health system*. This called for an inclusive, fair, safe and funded mental health system which recognises family and friends as a critical part of the recovery journey. MHCC staff appreciated the opportunity to talk to many of the attendees, as well as to attend the Tandem Awards ceremony held the same evening.

In October 2019, the Mental Health Complaints Commissioner, Dr Lynne Coulson Barr, also gave the opening address at the Mental Health Foundation Walk for Mental Health. This annual event is dedicated to breaking down stigma, building connections and raising awareness of the importance of mental health. The Commissioner's speech reached a crowd of over 10,000 people, including many consumers, families and carers.

In early 2020, MHCC staff and Advisory Council members engaged with many people in the LGBTIQ+ community by holding a stall at Victoria's Midsumma Carnival and walking in the Pride March. Both are celebrations of gender and sexuality diversity, pride and unity. At Midsumma we raised awareness of our role and encouraged LGBTIQ+ people to speak up about their experiences with the public mental health system. The Commissioner was interviewed alongside Ro Allen, Victoria's Gender and Sexuality Commissioner, on radio JOY 94.9.

Due to ongoing discrimination and other factors, LGBTIQ+ people experience greater mental health challenges, and more barriers to making a complaint about mental health services, than many others. The MHCC continues to work to ensure that we, and Victoria's public mental health services, are safe and accessible for them. The MHCC regularly shares information for the LGBTIQ+ community on its social media platforms and and has a dedicated brochure specifically to assist the LGBTIQ+ community to make complaints to the MHCC. We are also working towards Rainbow Tick accreditation.

In 2019–20 the Commissioner, the MHCC's Senior Adviser, Lived Experience and Education, and a youth member of the MHCC Advisory Council were also interviewed by the Youth Affairs Council of Victoria (YACVic). YACVic is the peak body and leading policy advocate for young people and the youth sector in Victoria. The two blogs produced reached over 3,000 young people and youth professionals who could potentially need the MHCC's help.

Service visits

The MHCC regularly meets with staff from public mental health services to discuss the most effective ways to resolve complaints. We analyse trends in complaint data, both statewide and relating to each service, and follow up on recommendations that have been made through resolving individual complaints. We also use meetings to review and provide feedback about local complaints processes and promote best practice in complaints handling. In 2019–20 we met with Forensicare, Ballarat Health, Eastern Health and the Royal Children's Hospital, among others. MHCC Resolutions staff who deal with complaints daily also have direct conversations with clinical staff and tailor education to the specific service.

Each complaint has produced reason for us to reflect and consider the way we provide service; how our ways of working impact people and how these can be improved or staff supported to ensure consumer-oriented care is our primary focus.

— Service provider

Education and training

Fantastic presentation and amazing work! You clearly hit the right note and I think we could have gone on for a lot longer given the number of questions and comments at the end.

— Audience member

The MHCC is a wonderful organisation who are absolutely critical to ensure that consumer/carer issues are truly heard by policy makers, hospital units and many others.

— Consumer

The MHCC's education and training focuses on people's rights under the *Mental Health Act 2014* (the Act) and how they apply to mental health service provision and complaint resolution. We also talk about people's rights under the 2006 Charter of Human Rights and Responsibilities and what this means for mental health service provision. In addition, we look at 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. In 2020, we published a summary of service responses to the MHCC's recommendations in *The Right to be Safe – Ensuring sexual safety in acute mental health inpatient units: sexual safety project report* (2018), to share progress that has been made and to highlight areas for continuing attention. We continue to highlight issues of sexual safety in our engagement work with services.

In 2019–20 we delivered 14 presentations to a range of audiences and seven education and training sessions to people working in mental health services and the mental health sector, reaching thousands of people in total.

Presentations at conferences are an important way in which the MHCC educates and engages people in key issues identified through our work. Topics featured in presentations during 2019–20 included questions such as 'Is the "care" missing from treatment? Reflections, stories and lived experiences in Victoria', which was presented by the MHCC Deputy Commissioner and Senior Adviser, Lived Experience at the National Mental Health Services (TheMHS) Conference, 'Building Healthy Communities: Stories of Resilience and Hope'. At the 20th Victorian Collaborative Mental Health Nursing Conference, the Commissioner reflected on the implementation of the Act and the establishment of the MHCC in her keynote presentation, asking 'Are we there yet? Reflections from the first five years of the Mental Health Complaints Commissioner'.

Human rights often feature in MHCC's presentations. At Safer Care Victoria's Giant Steps conference, MHCC staff talked about 'Upholding human rights in responding to mental health presentations', drawing attention to complaints about people's experiences of restrictive interventions, and in particular, the use of mechanical restraint in emergency department settings. The Commissioner also highlighted the importance of human rights in her webinar on 'Insights on COVID-19: Mental health impacts from complaints' for the Australian National University's roundtable on the 'Global impact of COVID-19 on Mental Health: Implications for policy and practice in Australia'.

Many of these presentations are also published and available for broader reach and education of the sector. For example, the Commissioner's presentation to the First National Equally Well Symposium (RMIT Campus, Melbourne, 28–29 March 2019), 'People's right to have to their medical and other health and disability needs recognised and responded to by mental health services: data and Insights from complaints to the MHCC', was published in the book of proceedings, *Equally Well in Action – Implementing strategies to improve the physical health of people living with mental illness* (Charles Sturt University, 2019).

In addition to the above presentations, in 2019–20 the MHCC presented at a range of other events and conferences including the launch of Mental Health Week, mental health sector forums and education conferences, and the Office of the Public Advocate's volunteer conference.

In response to requests from services and organisations, the MHCC also delivered education and training sessions on our role and approaches to complaints to staff and advisory groups of clinical mental health services including Bendigo Health and St Vincent's Hospital, the Mental Health Tribunal, the NDIS Quality and Safeguards Commission and Psychiatric Registrars in the Masters of Psychiatry course at the University of Melbourne. The MHCC also co-hosted an RU OK? Day event with the Disability Services Commissioner for the staff of both statutory bodies. A detailed list of activities is in Appendix 2.

Sector engagement and events

In 2019–20 the MHCC engaged with the mental health sector in a variety of ways. MHCC staff participated in 19 sector events including conferences, forums and launches of new initiatives and reports.

Participating in these sector events enables the MHCC to:

- connect with stakeholders and raise awareness of the MHCC's role
- learn about issues and developments in the sector
- contribute the MHCC's experience of safeguarding human rights, complaint resolution, investigations and mental health service improvement to broader systemic change.

Sector events included the Safer Care Victoria Giant Steps conference, the Mental Health Access and Quality in Emergency Departments conference and the launches of the DHHS Lived Experience Workforce Strategy and the Orygen National Centre for Youth Mental Health.

The MHCC also attended briefings on the draft report of the Productivity Commission Inquiry into Mental Health and interim report of the Royal Commission into Victoria's Mental Health System. Participating in these events and briefings ensures that we maximise our contributions to key issues and developments in mental health service provision and reforms, as well as align our work and efforts with new approaches and initiatives. This is also supported by our broad range of stakeholder engagement activities, including regular liaison and consultation meetings with the DHHS, the Chief Psychiatrist, other Commissioners and statutory bodies and advocacy organisations.

Submissions, consultations and contributions to projects

In 2019–20 we contributed to 17 sector consultations and projects, made submissions or provided formal feedback in 10 matters, contributed as a member of six advisory and reference groups and judging panels, and participated in 67 other stakeholder meetings and events.

These activities enable us to contribute to broader mental health service improvement and reform and ensure that our work is connected to and informed by the work of other key stakeholders in the sector. These activities are discussed in 'Promoting service and system improvement' and a full list of activities is included at Appendix 2.

Leadership visits

In September 2019 our Commissioner attended the International Initiative for Mental Health Conference in Washington DC, where she also participated in a Leadership Exchange on 'Understanding the Impact of Trauma Across Systems' with the National Association of State Mental Health Program Directors (NASMHPD) Centre for Innovation in Trauma Informed Approaches.[23] The aim was for mental health leaders to share innovations and network and problem-solve across agencies and countries on common issues impacting on mental health and wellbeing.

The Commissioner also visited a consumer-led acute service, Tupu Ake, operated by Pathways in New Zealand, which offers an inspiring alternative to emergency department presentations and acute inpatient admissions. People receiving services are called guests and provided with a range of individualised supports and activities (including gardening, mindfulness training, art, music, sensory resources and a therapy dog), as well as peer recovery programs and peer worker training programs. Only a very small percentage of people referred there have an acute inpatient admission later.

The Commissioner shared what she learned about these innovative programs and approaches with staff, the mental health sector and the Royal Commission into Victoria's Mental Health System.

23 The Commissioner paid for her overseas travel and was supported to attend these events while she was in the USA.

Communications

At the end of 2019–20, the MHCC had:

- Website: 48,691 page views and 20,852 sessions
- E-bulletin: 720 subscribers
- LinkedIn: 1,600 followers
- Facebook: 3,100 followers
- Twitter: 1,400 followers
- Instagram: 137 followers (started 15 April 2020)

The most significant social media growth was on LinkedIn, which the MHCC posted on more regularly than in previous years. The posts most engaged with across all four platforms in 2019–20 were those announcing the appointment of the MHCC's Deputy Commissioner, Maggie Toko. Other posts with a high level of engagement were those showing the MHCC's participation in events such as the National Walk for Mental Health, a feature about the MHCC's Easy English resource on people's right to make a complaint, and the announcement that the Royal Commission into Victoria's Mental Health System has recommended establishing a service designed and delivered by people with lived experience.

As outlined in the 'Learning and growing our capability' section of this annual report (page 70), in June 2020 the MHCC conducted a 'Tell us what you think' feedback survey, which included questions about the MHCC's communications. The feedback from the survey will inform our plans for social media and communications more broadly in 2020–21.

Engagement with the Aboriginal community

In 2019–20, the MHCC was delighted to welcome Dean Duncan, a proud Kamilaroi man, as the first Aboriginal member of our Advisory Council. Dean is the Executive Director of Education for the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and his appointment is the result of the supportive, collaborative relationship of our two organisations. We are working with Dean on ways of improving the awareness and accessibility of the MHCC for Aboriginal Victorians and ensuring the MHCC's communications and approaches are culturally responsive and safe. Dean has worked with staff and members of the Advisory Council on the MHCC Language Guide, ways of providing meaningful and personal acknowledgements to Traditional Owners, and the development of a plaque for the office. The plaque features the Aboriginal and Torres Strait Islander flags and a design of Bunjil the Creator Spirit for the Kulin Nation and says:

> *We Acknowledge the Wurundjeri People of the Kulin nation as the Traditional Owners/Custodians of the land on which we conduct our business.*
>
> *We recognise their continuing connection to land, water and community.*
>
> *We pay our respect to Elders past, present and the emerging leaders of the future.*

Over the coming year, we will be working with Dean to develop and implement a range of strategies to strengthen our engagement with and responsiveness to the needs of Aboriginal Victorians.

Learning and growing our capability

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

Our staff

Our staff have a wide range of skills and experiences, including lived experience and in mental health service delivery and programs, policy, law, social work, nursing and dispute resolution.

Aligning with our functions under the *Mental Health Act 2014*, the work of the MHCC is structured around four areas of focus, supported by an Executive Services team:

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

Driven by lived experience

People with a lived experience of mental health issues, as well as families and carers, hold uniquely valuable insights into how mental health services can best respond to people's needs and promote recovery. The MHCC, in resolving complaints about services and recommending improvements, understands how important it is to be driven by lived experience in everything we do.

The majority of our Advisory Council members have lived experience as a consumer, family member or carer, as do many of our staff. A member of the MHCC Advisory Council with lived experience, or the MHCC's Senior Adviser, Lived Experience and Education, is also part of every interview panel we hold for new staff.

The voices of people with lived experience, both within and outside our organisation, inform the design, development and delivery of all our work. To shape how this is done we have developed a principle, a framework, a strategy and a graphic representation of our values that will be monitored and evaluated over time. For more information, please see the 'Lived Experience and the Advisory Council' section of this annual report on page 13.

Learning and improving from feedback

The MHCC seeks feedback in a range of ways, including through:

– our website and social media platforms
– 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 to make improvements to how we work.

The 'Tell us what you think' feedback survey

In June 2020, we sought feedback about people's experiences with us to help us identify what elements of our work and approach our stakeholders feel are most valuable, and where we can improve. Our survey questions focused on the statements we developed through the *Driven by Lived Experience* project which describe what we'd like people's experience of engaging with us to be, and how we work to ensure we are driven by lived experience (see 'Lived Experience and the Advisory Council' on page 13). Orima Research were engaged to collate and summarise our survey findings.

We asked for feedback from:

- people who had made a complaint that had been closed within the previous six months (27 responses received)
- mental health service staff (36 responses)
- our Advisory Council (8 responses)
- our general subscriber and social media audiences (69 responses).

Overall, and across the survey groups, the most valuable parts of the MHCC's work were seen as:

- giving a voice to people accessing or trying to access mental health services and supporting them to address their concerns
- being an objective and independent third party in the complaints process
- safeguarding people's rights and highlighting areas of improvement for services and the sector.

Both people who had made a complaint and services were generally positive about their interactions with MHCC staff:

Of people who had made a complaint:

- 88 per cent of respondents felt they were asked respectful questions and were listened to
- 78 per cent of respondents felt heard and valued.

Of mental health service staff:

- 94 per cent reported the MHCC is guided by the views and preferences of the consumer and/or carer in working with the service to resolve complaints
- 86 per cent felt MHCC staff respectfully convey to the service the impact that the experience has had on the person making the complaint
- 83 per cent reported that MHCC staff worked with the service in a respectful way and sought to understand the service's perspective
- 82 per cent felt the MHCC's decisions are based on fair and transparent processes.

Responses from people who had made a complaint and from mental health service staff indicated that areas for improvement for the MHCC include communication and flexibility. For example:

- 48 per cent of people making a complaint felt they could choose how they wanted to participate in the complaint process
- 71 per cent of mental health service staff felt the MHCC was flexible in how they worked with the service
- 60 per cent of mental health service staff felt the MHCC does what it says it will do
- 57 per cent of mental health service staff felt the MHCC communicates regularly about actions and outcomes.

'Free text' comments both from people who had made a complaint and from mental health service staff also indicated that the MHCC should continue to make improvements in the timeliness and consistency of our responses to complaints. Comments from services also indicated the value of the MHCC continuing its efforts to share learnings between services and work closely with services to understand their perspectives.

MHCC Advisory Council members reported very positive experiences with the MHCC, with all respondents reporting that the MHCC encourages and values lived experience at every level and that it is influenced, informed and driven by the diversity of people's lived experience and backgrounds. Advisory Council members' comments indicate they value the inclusive leadership and genuine collaboration they experience as members. Other comments noted their wish to engage in more sector reform work in future.

In our general survey, we also sought feedback about the effectiveness of our communications. Most respondents perceived the MHCC's communications as fairly clear, inclusive and accessible, although the results also indicated that consumers were less likely to share this view than services and/or carers and family members. As such, this is an area for improvement. Our communications were seen as most effective in communicating core messages about being able to make a complaint, being able to complain to the MHCC or the service directly, and that people should not be treated unfairly because they have made a complaint.

We will report the feedback in detail on the MHCC's website as well as the actions taken and planned in response.

I had a feeling that the people at MHCC I spoke to were genuinely wanting to support mental health patients.

— Consumer

Highly professional, respectful but determined to ensure change.

— Consumer

[The MHCC made] efforts to understand the service perspective [and give] guidance regarding the resolution of complaints in a supportive way.

— Service provider

The MHCC has had a clear commitment to the experiences and voices of people with a lived experience.

— Advisory Council member

Complaints about the MHCC

The MHCC is committed to demonstrating the value of complaints and has a proactive and rigorous approach to responding to concerns people raise about their experiences with the MHCC. In 2019–20 we responded to concerns about the adequacy of steps taken by us, our process, and decisions made. In some 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 reconsidered the decision or took additional steps. 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 approach or when we made a mistake. For example, in one matter, internal review identified that we had provided incorrect information about the consumer's concerns to the service. In another case the consumer provided feedback that we had not accurately summarised her concerns in our letter to the service seeking a written response.

We share complaints about the MHCC among staff in order 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.

Practice review

In 2019–20 the MHCC drew on the feedback we have received to continue to develop our practice, processes and approaches. Continuing the practice review we started last year, the MHCC's Resolutions and Review Team:

- developed practice guidance based on each principle of the *Mental Health Act 2014* with Lived Experience consultant Helen Glover to guide the kinds of questions we ask of both people making complaints and mental health services
- reviewed, shortened and simplified the questions asked in our online complaint form and ensured they are inclusive, culturally safe and accessible. This was informed by consultations with Victorian Transcultural Mental Health, the Gender and Sexuality Commissioner's office and the Victorian Aboriginal Community Controlled Health Organisation, as well as relevant guidelines and standards
- reviewed how we categorised issues raised in complaints about medication, communication and access to enable more meaningful reporting and better inform systemic improvements
- created a new issue category and process to capture and report complaints and concerns that relate to COVID-19. This data has been very useful in informing the MHCC's weekly meetings with the DHHS during the COVID-19 response
- made publicly available a Language Guide for both internal and external use that helps ensure all our communications are consistent, inclusive, respectful, non-stigmatising and accessible.

Building our capacity: learning and development

I always found the MHCC has a real commitment to continuous improvement.

— Advisory Council member

MHCC staff are committed to finding and participating in regular opportunities for learning and development in order to improve our practice and better respond to people making a complaint.

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

All our staff have regular opportunities to attend mental health sector events and gain more understanding of new approaches and best practice in mental health, including learning from the clinical expertise or lived experience of others (see 'Education and Engagement', page 66).

We also ensure that all staff participate in training around human rights, Aboriginal cultural safety and LGBTIQ+ inclusive practices.

In 2019–20 staff undertook learning and development activities that included:

- all-staff training on lived experience and mental health principles by Helen Glover
- 'Trans and Gender Diverse Inclusive Practice' training run by cohealth/Zoe Belle Gender Collective
- 'Trans and Gender Diverse Inclusive Practice' led by representatives from Transgender Victoria
- 'Aboriginal Cultural Safety Training' with VACCHO
- 'Providing a meaningful acknowledgement to Traditional Custodians' with Dean Duncan, MHCC Advisory Council member and VACCHO Executive Director, Education Training Unit
- the inaugural Compassion Revolution conference
- 'Conciliation in the Shadow of the Law' seminar
- Office of the Public Advocate (OPA) forum: 'Humane staff required to deliver cruel care? The dilemma of restrictive interventions in aged care'
- National Regulators Community of Practice & ANZSOG webinar: 'How do we know we're good at what we do? Measuring regulatory performance'
- Institute of Public Administration Australia (IPAA) seminar on community engagement strategies
- Leadership Victoria training: 'Leading on the Edge'
- Resolution Institute accredited mediation training and online dispute resolution training in a range of areas, including working with an interpreter, resolving disputes on the telephone, online dispute resolution and narrative mediation.

Health, Safety & Wellbeing group

A healthy workplace is one where workers and managers collaborate to continually improve the health, safety and wellbeing of all workers and by doing this, sustain the productivity of the business. – World Health Organisation (WHO)

The MHCC is committed to providing a workplace that is safe and takes a proactive and holistic approach to employee health and wellbeing. Accordingly, the MHCC established a Health, Safety and Wellbeing Group (HSW Group) in 2019 with terms of reference to support and facilitate this work.

Chaired by Deputy Commissioner Maggie Toko, the HSW Group organised a range of activities over 2019–20, including online mental health tips, mindfulness training, reflective practice sessions and an information session on the DHHS's Employee Wellbeing and Support program. It has also progressed the implementation of the Institute for Healthcare Improvement's *Framework for Improving Joy in Work*, starting with a survey for staff on what makes for a good day at work and suggestions for supporting people's health and wellbeing during the COVID-19 crisis and remote working arrangements.

Whether working together in a physical office, or remotely from home, the HSW Group ensures staff are supported, connected and have access to new tools that aid their physical and mental wellbeing.

Appendices

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, and 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.

'4 As' of complaint resolution

The 4 As describe positive outcomes that can result from a complaint:
– *Acknowledgement* of a person's experience
– *Answers* or explanations about the complaint issues
– *Actions* taken because of the complaint
– *Apologies* for the person's experience.

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'.

Carer, young: A person under 18 years who provides care to another person, who (a) has a disability; or (b) is older; or (c) has a mental illness; or (d) has an ongoing medical condition (including a terminal or chronic illness or dementia).

Care relationship: When a person receives care from or provides care to another person because one is older or has a disability, mental health challenges or an 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 10002:2018). Complaints to the MHCC can be made orally or in writing. The MHCC seeks to resolve complaints informally, where appropriate. For a complaint to be formally accepted, it must 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 can 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: These are both 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 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 rights 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 provide information and make recommendations to mental health service providers, the Chief Psychiatrist, the Secretary of the DHHS, the Minister for Mental Health in Victoria, and other agencies listed in s 228(j) of the Act.

Recovery: From the perspective of the individual with mental health challenges, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

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 or actions 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

12th Victorian Public Sector Women's Leadership Summit – Keynote presentation

20th Victorian Collaborative Mental Health Nursing Conference – Keynote presentation

Australian National University Roundtable: *Global impact of COVID-19 on Mental Health* – Webinar Presentation

Canberra Mental Health Forum (via Zoom)

DHHS Mental Health Community Mental Health Sector COVID-19 Forum

DHHS Mental Health Sector Forum

Melbourne Mental Health Conference – Ausmed CPD Education for Nurses

Mental Health Foundation Australia – Mental Health Week Event – Walk for Mental Health – Opening address

Mental Health Foundation Australia – Official Launch of Mental Health Month – Opening Address

Mental Health Foundation Multicultural Dinner – 'Better Mental Health for All' – Special guest speaker

Office of Public Advocate Volunteers Conference

Safer Care Vic Giant Steps conference – Presentation on MHCC complaints, human rights and restrictive interventions

The Mental Health Services (TheMHS) 2019 National Conference – 2 presentations

02. Education and training activities

Bendigo Health Mental Health Program staff – Education session

Master of Psychiatry – Special Topics in Psychiatry, Melbourne University

Mental Health Tribunal Members Forum – Session on MHCC complaints and Mental Health Principles

NDIS Quality and Safeguards Commission – Presentation on role of the MHCC and referral processes

RMIT Social Work Students – Session on MHCC and trauma-informed practice

RUOK? day event and education session

St Vincent's Hospital joint Family and Carer Participation Committee & Consumer Reference Committee meeting

03. Service visits and meetings about complaint data and themes

Ballarat Health

Eastern Health

Forensicare

Royal Children's Hospital

04. Consumer and carer engagement activities

JOY 94.9 radio interview with Commissioner at Midsumma Carnival

JOY 94.9 radio interview with Deputy Commissioner on MHCC and COVID-19 impacts

Tandem Carers Awards

Tandem CEO, Carers advocate and members meetings

Tandem Conference 'Working in Tandem: for a compassionate mental health system' 2019 (including information stand)

VMIAC 'Listen Up Listen Louder' Conference 2019 (including information stand)

VMIAC CEO and members meetings

05. Broad reach activities

Mental Health Foundation Walk for Mental Health – Opening speech by Commissioner

Youth Affairs Council Blog articles on interviews with Commissioner and Senior Adviser, Lived Experience & Education, Advisory Council member

Midsumma Carnival (including information stand) and Midsumma Pride March

06. Contributions to consultations and projects

Australian Commission on Safety and Quality in Health Care – Open Disclosure Implementation Consultation

Australian Commission on Safety and Quality in Health Care – Consultation on National Safety and Quality Digital Mental Health Standards

Chief Mental Health Nurse's project work on sexual safety and responses to *The Right to be Safe* recommendations

DHHS Intersex Resources Project

DHHS Restrictive Practices Statutory and Regulatory Authorities Roundtable

Disability Worker Regulation Scheme – Consultation on proposed regulations

Health Legislation Amendment and Repeal Bill 2019 – Consultation on consequential amendments to *Mental Health Act 2014*

Inner Melbourne Community Legal – PACER Project

Joint Mental Health Commissioners Group response to request from Productivity Commission Mental Health Inquiry

National Mental Health & Wellbeing Pandemic Response – consultations with Mental Health Commissioners Group

National Mental Health Commission 'Vision 2030' consultation

National Mental Health Commission – National Peer Workforce Development Guidelines

National Stigma Report Card Project by SANE Australia – Panel participant

Productivity Commission Mental Health Inquiry – MHCC hosted consultation session with MHCC Advisory Council, Mental Health Tribunal and Independent Mental Health Advocacy advisory groups

University of Melbourne Research Project on 'Informing a national strategy to reduce stigma and discrimination towards people with mental illness' – the MISRed project

Victorian LGBTIQ+ Strategy Consultation

Victorian Mental Health Interprofessional Leadership Network's sexual safety guidelines project undertaken for the Chief Psychiatrist

07. Submissions and formal feedback

Ambulance Victoria – Accessibility Action Plan

DHHS Mental Health Care COVID-19 response – Inpatient consumer pathways

DHHS Victorian Nurse Practitioners Prescribing Consultation

Disability Worker Regulation Scheme – Proposed Regulations

National Mental Health & Wellbeing Pandemic Response – contributions to draft paper for National Cabinet

Productivity Commission Mental Health Inquiry – Response to Draft Report

Royal Commission into Victoria's Mental Health System – Commissioner's Witness Statement

Royal Commission into Victoria's Mental Health System – Submission

Safer Care Victoria clinical guidelines for *Caring for People Displaying Acute Behavioural Disturbance in Emergency Settings*

Safer Care Victoria Mental Health Clinical Network – *Improving How Consumer Completed Measures are Used in Clinical Mental Health Services*

08. Participation in advisory and reference groups and panels

Participation in advisory and reference groups

DHHS Lived Experience Advisory Group (Associate member)

DHHS Progress Measures Working Group

Office of the Chief Psychiatrist Sexual Safety Committee

Safer Care Victoria Mental Health Clinical Network Insight Subcommittee

Second Psychiatric Opinion Service Advisory Group

Victorian Ombudsman OPCAT Investigation Advisory Group

Participation in judging panels

Victorian Premier's Volunteer Champions Awards 2019 – Judging Panel

Victorian Public Healthcare Awards 2019 – Judging Panel

09. Other stakeholder meetings and events[24]

Australian and NZ Disability Commissioners meeting

Australian and NZ Health Complaints Commissioners meeting

Australian and NZ Mental Health Commissioners meetings

Australian and NZ Mental Health Commissioners Zoom meetings on COVID-19 impacts and National Response

Australian Health Practitioners Regulation Agency (AHPRA) – liaison & consultation meetings and briefings

Commission for Children and Young People – liaison & consultation regarding *Lost, not forgotten* report

Commissioner for Senior Victorians – liaison & consultation meetings

COVID-19 responses liaison and consultation meetings with the DHHS/OCP

DHHS liaison and consultation meetings

DHHS Mental Health Branch/OCP Governance meetings

DHHS Secretary – liaison and consultation meetings

Disability Services Commissioner – liaison & consultation meetings

Executive Director and staff, Headspace, Victoria – liaison & consultation meeting

Health Complaints Commissioner – liaison & consultation meetings

Independent mental health advocacy (IMHA) – liaison meetings

Mental Health Reform Victoria – liaison & consultation meetings

Mental Health Tribunal – liaison & consultation meetings

National Mental Health Commission CEO – liaison & consultation meeting

Office of the Chief Psychiatrist – liaison & consultation meetings

Public Advocate – liaison & consultation meetings

Safer Care Victoria – liaison & consultation meeting

VACCHO – Meeting with CEO and Executive – liaison & consultation meeting

Victoria Legal Aid CEO – liaison & consultation meetings

Victorian Agency for Health Information – liaison & consultation meeting

Victorian Commissioner for Gender and Sexuality – liaison & consultation meeting

Victorian Disability Worker Scheme Commissioner – liaison & consultation meetings

Victorian Equal Opportunity and Human Rights Commission – liaison & consultation meeting

Victorian Equal Opportunity and Human Rights Commission Joint Commissioners meeting

Victorian Transcultural Mental Health – consultation meeting

Visit to Pathways, Auckland New Zealand – Acute alternative and consumer-led services

24 There was more than one meeting with some stakeholders and groups, totalling 80 meetings.

10. Sector Events

DHHS Lived Experience Workforce Strategies Launch

DHHS Mental Health Community Mental Health Sector COVID-19 Consultation meetings

IMHA/VLA Seminar

International Day for People with Disabilities – Disability Services Commissioner event

International Initiative for Mental Health Leadership – Leadership Exchange and Conference

Mental Health Access & Quality in Emergency Departments Conference

Orygen National Centre for Youth Mental Health – Opening event

Out of the Madhouse Book Launch – SANE Australia

Productivity Commission's briefing on draft report for the mental health inquiry

Rotary International Women's Day Breakfast

Royal Commission into Victoria's Mental Health System – Briefing on Interim Report

Safer Care Victoria Giant Steps Conference

Victorian Equal Opportunity and Human Rights Commission Human Rights Oration 2019

Victorian Health Care Association Mental Health Sector Forum

Victorian Premier's Volunteer Champions Awards Ceremony

Victorian Senior of the Year Award Ceremony

11. Projects (internal)

Individual Service Provider Complaint Reports – consultations & feedback from services and MHCC Advisory Council

MHCC Lived Experience Framework

Revision of Complaint form – consultations with Victorian Transcultural Mental Health, Equality Branch Department of Premier & Cabinet, and MHCC Advisory Council

12. Publications

'People's right to have to their medical and other health and disability needs recognised and responded to by mental health services', in Charles Sturt University (2019), *Equally Well in Action: Implementing strategies to improve the physical health of people living with mental illness. Proceedings of the First National Equally Well Symposium*, RMIT, Melbourne, Vic. March 2019.

Appendix 3:

Operations

Financial statement for the year ended 30 June 2020

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

The financial operations of the MHCC are consolidated into those of the 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 2019–20 according to DHHS accounts is provided below. The expenditure was less than the allocated budget of $4,174,075 due to the deferred activities and unexpected staff vacancies resulting from a range of factors, most notably the COVID-19 pandemic.

Operating statement for the year ended 30 June 2020

Expenses	
Salaries and on-costs	$3,132,542
Contractors/external services	$243,697
Supplies and consumables	$524,375
Total expenses	**$3,900,614**

Staffing

25.06 FTE (including fixed-term positions) as of 30 June 2020, plus contractors engaged to perform specified functions and assist the MHCC to respond to the volume and complexity of complaints.

Appendix 4:
Compliance and accountability

Privacy and Data Protection Act 2014 and *Health Records Act 2001*

The 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

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.

In 2019–20 the MHCC made four decisions relating to freedom of information (FOI) applications. We also responded to an additional six requests for documents that were provided outside of the FOI process.

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 complaints and doing our work.

Public Interest Disclosures Act 2012

The *Public Interest Disclosures Act 2012* encourages and assists people to report improper conduct by public officers and public bodies and protects people from detrimental action as a result of making the disclosure.

Disclosures of improper conduct or detrimental action by the MHCC or its staff can be made to the Independent Broad-based Anti-corruption Commission (IBAC). Contact details are:

GPO Box 24234
Melbourne VIC 3000
Phone: 1300 735 135
www.ibac.vic.gov.au

More information about the *Public Interest Disclosures Act 2012* is available from IBAC's website at www.ibac.vic.gov.au.

Everyone's experience matters.

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

Level 26, 570 Bourke Street
Melbourne VIC 3000
Australia

Phone: 1800 246 054
Fax: (03) 9949 1506
Complaints: help@mhcc.vic.gov.au
Feedback: feedbackaboutus@mhcc.vic.gov.au
Other: info@mhcc.vic.gov.au

www.mhcc.vic.gov.au

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MHCC MENTAL HEALTH COMPLAINTS COMMISSIONER