1 August 2018

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

Dear Minister,

I am pleased to provide you with the annual report of the Mental Health Complaints Commissioner for the financial year 2017–18.

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

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

Yours sincerely

Dr Lynne Coulson Barr
Mental Health Complaints Commissioner

Commissioner’s message 02
Year at a glance 04
About the Mental Health Complaints Commissioner 06
Advisory Council 10
Safeguarding rights and resolving complaints 12
Local complaints reporting 34
Promoting service and system improvement 41
The MHCC’s Sexual Safety Project 46
Education and engagement 60
Learning and growing our capability 67
Appendices 73
Appendix 1: Education and engagement activities 74
Appendix 2: Operations 77
Appendix 3: Compliance and accountability 78
The right to be safe: Ensuring sexual safety in acute mental health services.

In March 2018 with the launch of our office, the need for concerted and committed actions to ensure people’s safety in other significant avoidable harms in mental health services, highlights the importance of meaningful, responsive and committed community members and consumer and advocacy organisations in assisting people to raise their concerns, and the way in which staff in services work with our office to achieve improved outcomes from complaints.

The findings and recommendations of this report demonstrate how complaints can provide a vital window into the gravity and impact of people’s experiences and the actions that need to be taken to ensure people’s safety, uphold their rights and drive positive change in mental health services.

The themes identified from complaints to our office and reported by services tell us that much more needs to be done to ensure consumers are at the centre of their care and treatment, and that they are safe and feel safe in services. These themes also speak to the continued need for recovery-oriented practice, supported decision making and trauma-informed care to be truly embedded in service provision, and for there to be a greater understanding of the role of family members, carers and other support people in the recovery and wellbeing of consumers.

The positive responses from the Department of Health and Human Services, the Chief Psychiatrist and mental health services to the findings and recommendations of The right to be safe, and to other service improvements recommended by our office, indicate that learnings from complaints are being used to drive positive changes in services and the system more broadly. This can also be seen in the 184 service improvement actions recorded as outcomes from complaints, which is more than double the number of actions recorded in 2016–17.

Throughout the coming year, we will be working closely with the department, the Chief Psychiatrist and mental health services on ways in which these planned actions will translate into real and sustainable changes in people’s experiences of services.

The number of enquiries and complaints raised with our office rose to 2,125 this year, which is a 21 per cent increase on last year and is almost one and a half times more than the number in our first year of operation. It is important to see this progressive increase in mental health complaints as representative of the value of having an accessible and specialist avenue for people to raise their concerns, and the increase in people’s awareness, confidence and preparedness to make a complaint.

Our team has worked with commitment and dedication over the past year to meet this significant increase in demand, responding effectively to people’s individual concerns and assessing and addressing the broad range of service provision issues identified in complaints. Our complaints resolution processes continue to highlight the ways in which meaningful acknowledgements, answers, actions and apologies by services can achieve positive outcomes for people who make a complaint.

We can never lose sight of the importance of responding to people’s individual needs and concerns and the difference that a positive resolution of a complaint can make to a person’s wellbeing and recovery and future engagement with services. In some cases, the resolution of a complaint can be a lifeline to a person who may not have otherwise sought further help from mental health services. To this end, our education and engagement work with services focuses on effective approaches to resolving individual complaints, as well as using data and themes from complaints to inform practice change and quality improvements. Our approach to investigations also focuses on the actions services need to take to address and resolve the issues arising from the person’s individual experience, as well as the actions and service improvements required to prevent a similar incident from occurring in the future.

I want to take this opportunity to acknowledge and thank the MHCC team for the passion, care and commitment they bring to their work each day. We acknowledge the support of consumer, carer and advocacy organisations in assisting people to raise their concerns, and the way in which staff in services work with our office to achieve improved outcomes from complaints.

I also thank the members of the MHCC Advisory Council, under the leadership of Chair Anthony Stratford, for contributing their lived experience expertise and knowledge of mental health service provision to inform our strategic directions and guide and shape our work. Together, we are working to develop a lived experience framework to inform and drive the work that is undertaken across our office and to articulate the ways in which the principles of co-design and co-production are applied in our work.

I thank the Hon Martin Foley, Minister for Mental Health, and the Secretary to the Department of Health and Human Services for their continued strong support and commitment to the role of our office. I also acknowledge the departmental officers who support our operations, the Office of the Chief Psychiatrist, clinical and executive directors of services, our colleagues in other statutory bodies and the many committed community members and consumer and carer organisations that share our goal of effecting positive change.

We look forward to continuing to work with all our stakeholders to ensure the voices of consumers, families and carers are being heard and that complaints are seen as integral to improving the quality and safety of mental health services in Victoria.

Dr Lynne Coulson Barr
96% of in-scope complaints closed with positive outcomes through MHCC processes and/or direct resolution actions by services.

2448 cumulative total of matters dealt with in 2017–18.

10176 information products distributed.

113 formal recommendations to the Secretary to the Department of Health and Human Services, the Chief Psychiatrist and mental health services.

1702 in-scope complaints reported by public mental health services for 2017–18.

2125 new enquiries and complaints.

1929 people reached through our education and engagement activities*.

337 matters being dealt with at any one time, on average.

51 other stakeholder meetings and events.

34426 visits to our website.

100+ people consulted for the MHCC Sexual Safety Project*.

38 contributions to sector consultations and projects, submissions and formal feedback.

384 service improvements identified as outcomes of complaints.

4300 social media followers across Facebook, Twitter and LinkedIn.

60 direct education and engagement activities#.

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

* Including consumers, families, carers, service staff and other stakeholders

# Including presentations, training sessions and other activities

^ Including consumers, families, carers, service staff, professional bodies, peak bodies, government and advocacy organisations.
ABOUT THE MENTAL HEALTH COMPLAINTS COMMISSIONER

Gabriel said he didn’t think he needed to be treated in the intensive care area of the inpatient unit, or that the service had adequately explained why he needed to be treated in this area.

Drawn from Gabriel’s complaint on page 25.

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 Act to ensure accuracy of meaning.

MEANINGS OF WORDS AND TERMS USED IN THIS REPORT
Consumer: a person who has accessed mental health services
Services/public mental health services: designated mental health services and publicly funded mental health community support services
Designated mental health services: public mental health clinical services prescribed under the Act that may provide compulsory assessment and treatment to 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 with a mental illness that are provided by non-government organisations and that are publicly funded

The Mental Health Complaints Commissioner (MHCC) is an independent specialist statutory body established under the Mental Health Act 2014 (the Act) to safeguard people’s rights, resolve complaints about Victorian 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 MHCC’S ROLE AND APPROACH
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 fulfil our safeguarding function by supporting people who access mental health services, families and carers to raise concerns or make a complaint either directly to the service or to the MHCC. We have broad powers to deal with complaints about designated mental health services (as set out in the Mental Health Regulations 2014) and publicly funded mental health community support services (MHCSS). This includes National Disability Insurance Scheme (NDIS) funded psychosocial supports provided by MHCSS. We provide accessible, tailored and flexible resolution processes that respond to the unique and diverse needs of people who contact our office. We support early, local resolution of complaints between the person and the service.

We can formally investigate serious matters involving risk and safeguarding concerns identified in complaints. We make recommendations for service and system improvements and use our range of powers and functions under the Act to effect positive change and to promote and protect the rights of consumers.

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

As an additional oversight, all public mental health services are required under the Act to provide a biannual report to our office detailing the number of complaints made directly to their service and the outcomes of these complaints. We analyse this data and work with services to address the issues identified. Through our education and engagement, complaints resolution and local complaints reporting activities, we work with services to build their capacity to develop a positive complaints culture. This is a culture where people feel supported to raise their concerns and where services provide effective responses to complaints and initiate service improvements where identified.

We uphold the mental health principles and ensure people’s rights are promoted and safeguarded both in our own approaches to our work and in promoting improved awareness and responsiveness by mental health services. By providing avenues for people to raise their concerns, to be actively involved in resolution and decision-making processes, and to have their experiences heard and respected, we play an essential role in improving people’s experiences and supporting their recovery and wellbeing.
THE VALUE OF A SPECIALIST APPROACH TO MENTAL HEALTH COMPLAINTS

Complaints provide a vital window into people’s experiences of mental health services and can help highlight areas where improvements can be made.

When we started operation in 2014, Victoria became the first Australian state to establish a specialist mental health complaints body and has since recorded significantly more mental health complaints than any other jurisdiction.

The establishment of our office has provided an avenue for people’s experiences of mental health services to be heard and responded to in a centralised and comprehensive way. We do this by using information from complaints to systematically identify key areas of service provision requiring stronger responses from services.

A number of complaints led us to identify the need for further work to ensure the sexual safety of people accessing acute mental health inpatient treatment. In 2017–18 we completed our first major strategic project on this topic, the MHCC Sexual Safety Project, and launched The right to be safe project report.

The MHCC fulfils a unique role. We identify complaints learnings that can lead to positive actions and changes that address both individual concerns raised in complaints and benefit the community as a whole through service and systemic improvements.

OUR FUNCTIONS

The 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 make recommendations for improvements to services, the Chief Psychiatrist, the Secretary and the Minister
- to investigate and report on any matter relating to services at the request of the Minister.

THE MENTAL HEALTH PRINCIPLES

The mental health principles must be upheld by mental health services and by any person performing any duty or function under the Act, including the MHCC.

The Act sets out the following mental health principles (s 11(1)).

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

b) 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.

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

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

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

g) People 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) Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to.

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

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

l) Carers (including children) for people receiving mental health services should have their role recognised, respected and supported.
CO-PRODUCTION AND CO-DESIGN

Co-production and co-design are approaches that involve the people who use a service in designing, developing and delivering that service. Our commitment to co-production and co-design means that we seek to improve the experiences of people using our service by providing genuine opportunities for people with lived experience of mental health issues, families, carers and people working in services to participate in and shape our work.

Our objectives are for members to share their knowledge and expertise and provide advice across a range of areas, including in relation to the needs and priorities of people with lived experience regarding complaints processes and effective responses to complaints.

In 2017–18 we increased our level of engagement with the MHCC Advisory Council members in seeking their advice on the approaches we take to our work, their direct involvement in our key projects, and their assistance in facilitating greater input from consumers, families, carers and service providers.

Key contributions

The MHCC Advisory Council members met five times in 2017–18. Their contributions included:

- having input into key strategic projects including:
  - scoping a project to examine how we can more deeply embed the lived experience into our work
  - the MHCC Sexual Safety Project on ensuring sexual safety in acute mental health inpatient units, which included:
    - representation on the Project Reference Group including providing expert advice and input into project aims and activities
    - providing feedback on The right to be safe project report
  - attending our inaugural learning from complaints forum, where we launched the report and discussed lessons learnt through this project
  - providing feedback on our education and engagement initiatives and materials including:
    - the redevelopment of the MHCC website, where members provided feedback on the content, including our online complaint form, as well as the architecture, graphics, design and navigation
    - our annual report and highlights document, where members reviewed content and had input into the design
    - delivering presentations with MHCC staff, including as part of The University of Melbourne Master of Psychiatry course, where we engaged third-year registrars on our role and functions and best practice approaches to resolving complaints
    - sharing insights from their participation in national and state consultations on mental health sector issues
    - participating in discussions on our business planning, including in relation to priority areas for 2018–19, and reviewing progress against the MHCC’s strategic directions
    - delivering a training session to MHCC staff on the role of supported decision making in protecting people’s rights and ensuring choice
  - participating in a facilitated workshop with MHCC staff to review approaches to the MHCC’s core functions and the current measures of success for our work
  - participating in discussions on digital options to facilitate collaboration and the sharing of information among council members
  - being involved in our recruitment processes as consumer and carer representatives.

MHCC Advisory Council members

The MHCC Advisory Council is chaired by Anthony Stratford, who played an integral role in establishing the council and brings deep insights from his lived experience as a consumer, along with broad national and international experience in recovery-oriented practice, research, training and peer-led initiatives.

Our council membership includes:

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

Our council includes people who bring a range of different experiences and perspectives, including people of different ages, gender and sexual identities, and culturally and linguistically diverse backgrounds.

We are seeking to expand the council in 2018 to include specific positions for members of Victoria’s Aboriginal community. Our aim is to seek their knowledge, insights, guidance and advice on our work, including our efforts to ensure we provide Aboriginal people in Victoria with culturally responsive and accessible complaints processes for addressing their concerns.

In 2017 the council chair accepted the resignation of Paula Fernandez. We thank Paula for sharing her knowledge and experience from her work in local complaints resolution within a mental health service, and her dedication and contribution to achieving our shared goals. In 2018 we were pleased to welcome new council member Tom Wood, who brings insights from his lived experience as a consumer, peer worker and young Victorian.

The current MHCC Advisory Council members are:

- Anthony Stratford (chair)
- Christine Abdelmalek
- Robyn Callaghan
- Hanna Jewell
- Simon Katterl
- Rachael Lovelock
- Annette Mercuri
- Dr Steven Moylan
- Gloria Sleaby
- Tom Wood.
SAFEGUARDING RIGHTS AND RESOLVING COMPLAINTS

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

- assess all complaints against the requirements of the Act and the Charter as well as against relevant standards and guidelines.
- ensure that any complaints raising immediate concerns about people’s rights or other safeguarding issues are promptly escalated.
- support people who contact us to understand and exercise their rights through our complaints processes and also in their future experiences with mental health services (for example, we promote the uptake of advance statements and nominated persons as part of complaints resolution, support compulsory patients to understand and exercise their right to a second psychiatric opinion, and support people to access other services that can help them to exercise their rights including Victoria Legal Aid, independent mental health advocacy (IMHA), the Victorian Mental Illness Awareness Council (VMAC) and Tandem Carers).
- identify areas where rights are not being adequately promoted and protected and ensure action is taken to address this (for example, through staff education and training or policy and procedure change).
- ensure we hold services accountable for promoting and protecting the rights of consumers (for example, through seeking enforceable undertakings where a breach of people’s rights or the requirements of the Act has occurred – see page 15).
- use what we learn through complaints to inform strategic projects and recommendations (for example, through our project report, The right to be safe).

The right to be safe project report includes recommendations to mental health service providers, the Chief Psychiatrist and the Secretary to the Department of Health and Human Services on ways to ensure sexual safety in these environments. Throughout 2018–19 we will continue to work with stakeholders to support the implementation of the project’s recommendations to ensure people accessing inpatient treatment feel and are sexually safe.

The Mental Health Complaints Commissioner (MHCC) has a function under the Mental Health Act 2014 (the Act) to identify, analyse and make recommendations to services to ensure people’s rights are respected and promoted. The MHCC also ensures complaints that raise immediate concerns about people’s rights or other safeguarding issues are promptly identified and raised with the relevant service to ensure people’s rights are upheld.

To ensure mental health services are safe for the people who use them, we work collaboratively with services, the Chief Psychiatrist, the Department of Health and Human Services and other relevant statutory bodies to share information, including insights and knowledge gained about safeguarding people’s rights. Through our complaints processes, we assess service actions and responses against the requirements of the Act, the mental health principles, the Charter and relevant guidelines and standards. We also seek and take into account the views and preferences of the consumer at the centre of the complaint, as well as their support people. We draw on all of this information to identify ways to resolve complaints and make recommendations to services to ensure people’s rights are respected and promoted. We also draw on our analysis of issues relating to people’s rights and safety raised through individual complaints to inform our input into the strategic work of other organisations, and to guide our own strategic projects.

In 2017–18 we completed our first major strategic project about safeguarding issues that we identified through complaints made to our office and complaints reported to us by services. This project, titled the MHCC Sexual Safety Project, involved an analysis of complaints that raised issues about the sexual safety of people accessing treatment in acute mental health inpatient environments (for more information about the Sexual Safety Project, see pages 46–53).

The right to be safe project report includes recommendations to mental health service providers, the Chief Psychiatrist and the Secretary to the Department of Health and Human Services on ways to ensure sexual safety in these environments. Throughout 2018–19 we will continue to work with stakeholders to support the implementation of the project’s recommendations to ensure people accessing inpatient treatment feel and are sexually safe. We thank the department for their support of this project, which included funding two short-term investigator positions to enable this work to be undertaken, and for their commitment to implementing the report’s recommendations.
RISK AND SAFEGUARDING ISSUES

For all complaints, we assess practice against the requirements and principles of the Act, the National Standards for Mental Health Services, the National Safety and Quality Health Service Standards, Chief Psychiatrist guidelines and other relevant standards and guidelines. To assist this assessment in complaints involving risk and safeguarding issues, we may review relevant documentation including incident reports, clinical records, relevant policies and guidelines and 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 individual and for others. Through this process, we also aim to increase the ability of services to identify critical safeguarding issues and to take appropriate action to promote and uphold the rights of consumers.

Our Practice Review Project (see page 71) has included a strong focus on ensuring safeguarding issues are promptly identified and escalated internally, and to the service, to ensure people’s immediate safety. The project also focuses on refining our framework and approach for addressing the complex and serious issues raised in many of the complaints we receive.

OUR APPROACH

The Act enables the MHCC to use a variety of approaches in resolving complaints, depending on what is most appropriate for each complaint. Our options for dealing with complaints include:

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

OVERVIEW

The MHCC experienced increased demand for our services in 2017–18 from an already high base. We received 2,125 new enquiries and complaints, comprising 1,963 complaints and 162 enquiries. The proportion of complaints (92 per cent) and enquiries (eight per cent) was consistent with 2016–17 (93 per cent and seven per cent respectively), demonstrating that people have a strong understanding of the role of our office (see Figure 1).

Figure 1
breakdown of new enquiries and complaints made to the MHCC in 2017–18 compared with 2016–17
base: all enquiries and complaints raised with the MHCC (n = 2,125)

<table>
<thead>
<tr>
<th>Year</th>
<th>Enquiries</th>
<th>Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016–17</td>
<td>162</td>
<td>1,963</td>
</tr>
<tr>
<td>2017–18</td>
<td>162</td>
<td>1,963</td>
</tr>
</tbody>
</table>

UNDERTAKINGS AND BREACHES OF THE ACT

The Act enables the MHCC to use a variety of approaches to resolve complaints, depending on what is most appropriate for each complaint. Our options for dealing with complaints include accepting a formal undertaking from a service to take action, where appropriate.

In situations where an undertaking is made, the Commissioner may monitor the service to assess the action taken, and issue a compliance notice if she is satisfied that the service has not complied with the undertaking. It is an offence for a service not to comply with a compliance notice. The Commissioner has promoted the option of an undertaking as an important safeguard of the Act and a way in which services can demonstrate their commitment to taking action to address identified breaches of the Act.

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

EXAMPLE

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

Amar contacted the MHCC to make a complaint about his experience of being placed in seclusion during an inpatient admission. Amar raised serious concerns about staff using physical restraint to move him to the seclusion area and the trauma he had experienced as a result.

In our discussions with Amar, he said he did not want to continue with the complaints process because he wanted to put the distressing events he had experienced behind him and focus on his recovery. Because of the serious concerns raised about the use of seclusion and restraint, the Commissioner exercised her power under the Act to continue to deal with the complaint. We advised Amar of our intention and that we respected his wishes about the level of involvement he wanted in our assessment of the issues raised in his complaint.

We requested that the service review the use of restraint and seclusion in Amar’s case and provide a written response outlining how the requirements of the Act had been met, including whether less restrictive options had been considered and tried to respond to Amar’s behaviour. From this review, the service identified that some of the requirements of the Act had not been met, specifically in relation to monitoring and reporting the use of seclusion and restraint, and made a number of changes to practice and procedure to address the issues identified in Amar’s complaint.

To ensure compliance with the Act in future, the Commissioner requested and accepted an undertaking from the service that staff employed in the unit would receive annual training to reinforce their understanding of the requirements of the Act in relation to seclusion and restraint. As part of this undertaking, the service also agreed to conduct an audit of the service’s compliance with the provisions of the Act in relation to the use of seclusion and restraint for six months, and to provide a summary of the outcomes of the audit to the MHCC for review.

The undertaking requires the service to advise the Commissioner once the agreed actions have been implemented.
Of the complaints received in 2017–18, 1,636 were about people’s recent experiences in Victorian public mental health services (known as in-scope complaints) (see Figure 2). Complaints that were not about Victorian public mental health services were most commonly about private practitioners, other kinds of services or mental health services in other jurisdictions. When we receive complaints that are not within our jurisdiction, we help people to identify options for resolving their concerns, including referring people to the most appropriate body that can best meet their needs and resolve their concerns.

Including the complaints that were carried forward from 2016–17 (323), we dealt with a total of 1,959 in-scope complaints and 2,448 matters in 2017–18, a 21 per cent increase on the 2,029 matters dealt with in 2016–17. Figure 3 shows the continuing increase in total matters dealt with from the MHCC’s commencement in 2014–15 to 2017–18. Total matters raised with the MHCC in 2017–18 were almost one and a half times the volume received in 2014–15.

On average in 2017–18, 337 matters were open at any one time, a 20 per cent increase on 2016–17 (281), reflecting the increasing demand on our office.

Including the complaints that were carried forward from 2016–17 (323), we dealt with a total of 1,959 in-scope complaints and 2,448 matters in 2017–18, a 21 per cent increase on the 2,029 matters dealt with in 2016–17. Figure 3 shows the continuing increase in total matters dealt with from the MHCC’s commencement in 2014–15 to 2017–18. Total matters raised with the MHCC in 2017–18 were almost one and a half times the volume received in 2014–15.

On average in 2017–18, 337 matters were open at any one time, a 20 per cent increase on 2016–17 (281), reflecting the increasing demand on our office.

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

**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.

**HOW WE RECEIVE COMPLAINTS**
We receive complaints by phone, email, fax, letter and face to face, as well as through the online complaint form on our website and through our social media sites. Most contacts with our office are made through our 1800 phone line. In 2017–18 we received 7,790 calls through this phone line, a 25 per cent increase on the 6,219 received in 2016–17.

In 2017–18, 75 per cent of complaints were received by phone (1,468 of 1,963 new complaints), a slight increase on the 71 per cent received orally in 2016–17 (see Figure 4).

Most oral complaints we receive are about:
- treatment and care during an inpatient admission
- rights as a compulsory patient, including the extent to which people feel supported to make and participate in decisions about their treatment
- imminent discharge and associated concerns about discharge planning
- concerns for the safety and wellbeing of consumers and carers
- communication by staff with consumers, families and carers.

These issues often require an immediate response. Dealing with these complaints over the phone enables us to clarify the person’s concerns, understand the outcomes they are seeking and request their consent to contact the service to seek a responsive and timely resolution. It also allows us to facilitate a prompt response from the service and to support the person’s engagement with their treating team. Depending on the nature of the concern raised we may also refer to another complaints body to resolve their concerns (for example, the Health Complaints Commissioner) or support people to access other types of services including IMHA or Victoria Legal Aid, if we are not the most appropriate body to help them.

Responding to these complaints often requires significant time and skill on the part of our resolutions officers. They respond to people often calling in distress, assess complex issues and identify urgent risk and safeguarding issues that may need to be escalated immediately to the service to ensure the person’s safety and wellbeing.

Complaints involving safeguarding issues or quality and safety concerns usually require a formal response from the service. Our office’s assessment of that response ensures the actions services take adequately address the concerns raised. Where this is the case, we ask the person raising the concerns to make their complaint in writing, providing assistance where necessary. Formal responses are assessed by our staff, who seek and take into account feedback from the person making the complaint and/or the person at the centre of the complaint, with a view to both resolving the concerns and identifying improvements that will better support recognising and protecting people’s rights, safety and good practice. Where our staff identify quality and safety issues or questions of compliance with the Act, and assess that the response does not adequately address these issues, we may make formal recommendations to the service for changes or improvements to practice, processes or training, or consider other options including investigation.
PEOPLE WHO CONTACTED US

Of the 2,125 new complaints and enquiries made to the MHCC in 2017–18, consumers raised 1,579 (74 per cent) and family members and carers raised 440 (21 per cent). The remaining complaints and enquiries were made by advocates, legal representatives, friends and staff from other services, or were referred to us from other bodies (see Figure 5). This represents a slight increase in complaints and enquiries made by consumers compared with any other group during this reporting period, which is consistent with patterns seen in previous years.

Given the nature of our engagement with the people who contact our office, it is not always appropriate or possible to capture information on gender identity, age and cultural or linguistic background. We continue to work on ways of capturing this data and promoting the accessibility of our office to priority population groups. In 2017–18 we developed a new complaints form that allows us to capture this data for written complaints and a new resource for Aboriginal people on the mental health principles, the role and functions of our office and how to make a complaint about a public mental health service in Victoria (see page 54).

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

- assisting them to resolve their concerns directly with the service
- seeking the consent of the consumer for our office to accept the complaint
- considering if there are special circumstances that would allow us to accept the complaint without the consumer’s consent, and whether this would not be detrimental to the consumer’s wellbeing, in accordance with the provisions of the Act.

We recognise and respect the important role of families and carers in raising issues on behalf of consumers. When we accept a complaint from a carer or family member, we first seek consent from the consumer and work to involve the consumer in resolving the complaint whenever possible. The Act requires the consumer to be kept informed in writing about the complaint in all circumstances.

EXAMPLE COMPLAINT

Danielle is 25 years old and lives with her parents and carers, Amelie and Marc. Amelie contacted our office, concerned that Danielle had been discharged from an inpatient unit without Amelie or Marc’s knowledge while they were away on holiday, and that Danielle had returned home without her parents being there to support her. She also said the community mental health service had not contacted or visited Danielle after her discharge, despite this having been planned. In discussion with our resolutions officer, Amelie told us that she wanted to ensure that other consumers and families did not have similar experiences.

With Amelie’s agreement, we spoke with Danielle to discuss her views about the concerns raised by her mother and gained her consent to the complaint. Danielle said she didn’t want to be directly involved in the resolution process but did want to receive updates about the progress of the complaint from her mother.

Amelie told us that she wanted to try to resolve her concerns directly with the service. Accordingly, we advised the service of Amelie’s concerns and what she was seeking as an outcome of the complaint, and asked them to contact her directly to attempt to resolve her complaint.

When the service contacted Amelie, she explained her concerns about Danielle’s discharge and the lack of follow-up from the community team. The manager of the service confirmed that a referral had been made to the community team to request their involvement in Danielle’s treatment and care but that this had not been received. The service discussed the actions that they would take to ensure this would not happen again.

While the service’s initial response addressed some of Amelie’s concerns, our follow-up discussions with Amelie identified that the service had not confirmed the actions that they had agreed to take. We also assessed that there were serious questions as to whether the service had adequately considered the safety and support issues for Danielle and the principles of the Act that carers should be involved in decisions about assessment, treatment and recovery whenever this is possible and that carers should have their role recognised, respected and supported. The MHCC then formally wrote to the service to request a response to Amelie’s concerns that explained how the treatment and care that had been provided to Danielle met the requirements of the Act, and to confirm any changes that had been made as a result of the complaint.

In the written response, the service manager apologised for the internal communication issues that meant the referral to the community mental health team wasn’t received. The service manager explained that as a result of Amelie’s complaint, the internal referral process to the community mental health team had been reviewed, which led to changes to processes and further staff training. The service manager also explained that Danielle had been discharged from the inpatient unit because she had wanted to go home and the treating team had assessed that she no longer required inpatient treatment. The service manager advised that Danielle had not wanted her parents to be told when she was going to be discharged because she was worried that they would miss out on their planned holiday so they could be there when she returned home.

We discussed the service response with Amelie, which she also discussed with Danielle. Amelie appreciated the apology she had received and felt that the changes the service had implemented to improve internal referral processes would benefit others. However, she wasn’t satisfied with the service’s response about their decision to discharge Danielle. As well as seeking Amelie and Danielle’s views, we assessed the service’s response against the principles of the Act and principles of family-inclusive practice. We assessed that while the service had given appropriate regard for Danielle’s autonomy and wishes, we also identified ways in which the service could have engaged more proactively with Danielle to explore how her concerns about advising her parents of her discharge could be addressed and to involve them in discussions about discharge planning and support for her return home. We also sought confirmation from the service that their discharge planning processes emphasise the critical role of carers.

Amelie and Danielle’s experiences have informed our input into the Chief Psychiatrist’s work in progressing guidelines on working with families and carers as well as discharge planning guidelines.
Safeguarding rights and resolving complaints

MHCSS (68 complaints)
forensic/prison (155 complaints)
aged (55 complaints)
adult (1260 complaints)

This breakdown is similar to previous years. The continuing higher proportion of complaints about designated mental health services is most likely attributable to the significantly higher numbers of consumers accessing these services and the nature of compulsory treatment.

SERVICE PROGRAM TYPES

Of the in-scope complaints made to our office in 2017–18 where a program type was identified (1,626):

- 78 per cent were about adult mental health services
- 10 per cent were about forensic services (including services in prisons provided by designated mental health services)
- five per cent were about children and youth mental health services (CYMHS) or child and adolescent mental health services (CAMHS)
- four per cent were about MHCSS
- three per cent were about aged persons mental health services

Fifty-seven per cent of matters raised about adult services related to acute inpatient services, 37 per cent related to community mental health services, three per cent related to residential services including community care units and prevention and recovery care services, and the remaining three per cent were about other types of services (including secure extended care units, specialist inpatient services and mental health services provided in emergency departments).

Fifty-nine per cent of complaints about CYMHS or CAMHS related to community-based services, with 41 per cent relating to inpatient services.

The proportion of complaints about aged persons mental health services and CYMHS/CAMHS continues to be lower than the proportion of consumers accessing these services, indicating the need for the MHCC to continue targeted education and engagement activities to promote awareness of the role of our office among these age groups (for more information, see the ‘Education and engagement’ section on pages 60-66).

The MHCC has jurisdiction to accept complaints from prisoners where services are provided by designated mental health services. Prisoners made 688 calls to our office on a dedicated phone line for responding to concerns about mental health treatment in prisons, which represented nine per cent of all calls to our office and a 51 per cent increase from the 456 calls received in 2016-17. Some of this increase may be explained by the opening of Ravenhall Correctional Centre in November 2017 and new arrangements for prisoners to receive mental health services from Forensicare.

The majority of calls represented immediate issues about access to treatment or particular medications and were therefore dealt with as oral complaints requiring a facilitated response from the mental health service providing treatment within the prison.

KEY ISSUES IDENTIFIED IN COMPLAINTS ABOUT PUBLIC MENTAL HEALTH SERVICES

Complaints raised with our office are often complex, and most involve more than one issue. In this report, issues are described in terms of how often they occurred in in-scope complaints about experiences in designated mental health services and MHCC received in 2017–18 (number and frequency percentage of 1,636 complaints). In light of many cases having more than one issue, the frequency percentages do not equal 100 per cent.

In previous annual reports, issue frequency has been described in terms of all issues raised with our office (including out-of-scope complaints and enquiries). Limiting this analysis to complaints that represent people’s experiences with mental health services over the previous 12 months provides a more accurate and detailed picture of people’s concerns and experiences in the reporting period. For this reason, direct comparisons with previous years are not made in this section.

In 2017–18 treatment continued to be the most common issue identified in new complaints (71 per cent). Consistent with overall trends in previous years, the next most common issue was concerns about communication, consultation and information (raised in 53 per cent of new complaints), followed by issues about staff behaviour, competence and professional conduct (28 per cent) and medication (25 per cent).
Other frequently occurring issues in 2017–18 included specific issues about access to services (18 per cent), discharge and transfer arrangements (12 per cent) and environment, personal safety and management of the facility, which included concerns about sexual safety (11 per cent) (see Figure 7).

The common concerns raised about treatment, communication and staff behaviour are consistent with 2016–17, indicating the need for services to continue to work on ways to better support people to exercise their rights to make and participate in decisions about their treatment and care.

### Treatment Issues

Almost three-quarters of the complaints made to the MHCC related to wide-ranging concerns about treatment. The general themes of these complaints were similar to those observed in 2016–17. The most common issues related to concerns about the decision to provide compulsory treatment or the way this was conducted (29 per cent). While the Mental Health Tribunal reviews decisions about compulsory treatment, consumers often raise related issues with our office. These include concerns about whether or how adequately a consumer’s rights have been explained to them, the amount of information provided to them about their rights and timeliness of access to their records in preparation for a Tribunal hearing.

The next most common concerns related to the adequacy or effectiveness of treatment (16 per cent). This included concerns about the extent to which a consumer or carer’s views and preferences regarding treatment, including those set out in advance statements or related to the use of restrictive interventions, were taken into account.

Other treatment issues, which were consistent with previous years, included:

- complaints that treatment provided was excessive, particularly in relation to compulsory treatment
- disagreements about a diagnosis or concerns related to a lack of explanation about a diagnosis
- concerns about how a treatment plan was developed or followed
- complaints about the use of restraint
- delays in admission or treatment.

### Medication

Complaints about medication most commonly related to concerns about prescribing (17 per cent), followed by concerns about the administration of medication (six per cent).

### Communication Issues

The majority of complaints about communication related to inadequate inclusion of the consumer, family member or carer (including a nominated person) in decision making (23 per cent, an increase from 2016–17). A related but separate concern was about the adequacy of information or communication the service provided to the consumer, family member or carer (17 per cent).

As in previous years, these concerns point to the need for services to improve the way they meet the requirements of the Act in supporting consumers to make, or participate in, decisions about their treatment and to include support people such as family members, carers and nominated persons in this process. Effective communication is central to supported decision making, recovery-oriented practice and recognising and respecting the role of families and carers. As part of the process of resolving complaints about communication, the MHCC encourages people who contact our office to consider the benefits of making an advance statement or appointing a nominated person.

Other concerns included:

- complaints that incorrect or misleading information was provided
- issues relating to the right to communicate as set out in the Act and about restrictions on the right to communicate.

### Staff Behaviour and Conduct

Concerns raised about staff behaviour and conduct were broadly consistent with previous years and continued to focus on staff attitudes, including people experiencing interactions with staff as lacking empathy or respect (10 per cent). Concerns raised were about staff’s lack of attention to the consumer’s individual needs (eight per cent). These types of complaints highlight the need for services to continue to improve engagement with consumers, families and carers, and to ensure people feel heard and respected and that their individual, self-identified needs are placed firmly at the centre of their treatment and care.

We continue to receive a small but concerning number of complaints that involve significant risk and safeguarding issues. These include alleged discrimination, neglect or assaults, some of which are associated with episodes of restrictive interventions such as bodily restraint or seclusion. We prioritise these complaints to assess any immediate risk or safety issues for consumers and assess all complaints involving allegations of staff or practitioner misconduct for notification and referral to the Australian Health Practitioner Regulation Agency.

In our assessment and responses to these types of complaints, we take into account the adequacy of immediate actions and investigations undertaken by the service and the status of any police involvement. We also take into account the requirements of the Act and relevant guidelines that may apply to the particular issues raised in the complaint.

### TREATMENT ISSUES

Almost three-quarters of the complaints made to the MHCC related to wide-ranging concerns about treatment. The general themes of these complaints were similar to those observed in 2016–17. The most common issues related to concerns about the decision to provide compulsory treatment or the way this was conducted (29 per cent). While the Mental Health Tribunal reviews decisions about compulsory treatment, consumers often raise related issues with our office. These include concerns about whether or how adequately a consumer’s rights have been explained to them, the amount of information provided to them about their rights and timeliness of access to their records in preparation for a Tribunal hearing.

The next most common concerns related to the adequacy or effectiveness of treatment (16 per cent). This included concerns about the extent to which a consumer or carer’s views and preferences regarding treatment, including those set out in advance statements or related to the use of restrictive interventions, were taken into account.

Other treatment issues, which were consistent with previous years, included:

- complaints that treatment provided was excessive, particularly in relation to compulsory treatment
- disagreements about a diagnosis or concerns related to a lack of explanation about a diagnosis
- concerns about how a treatment plan was developed or followed
- complaints about the use of restraint
- delays in admission or treatment.
ACCESS TO SERVICES
Concerns about access to services related to the assessment process and the refusal of service including:
- dissatisfaction with the assessment process (five per cent)
- inappropriate, inadequate or no service provided (five per cent)
- refusal to admit or treat a person (four per cent)
- delays in accessing a service, including concerns about long waiting lists (three per cent).

These were consistent with themes from previous years. Concerns about access are complex and are affected by a range of factors. In resolving complaints about these issues, if a specialist clinical mental health service is not assessed to be the most appropriate service, we note the importance of services supporting people to access other appropriate treatment and supports to address their needs.

ENVIRONMENT, PERSONAL SAFETY AND MANAGEMENT OF THE FACILITY
A range of concerns continued to be raised about people’s safety, particularly in acute mental health inpatient units. The most significant concerns raised with our office included complaints where people felt unsafe in these environments and/or where incidents of alleged abuse, assault or intimidation by another consumer had occurred (complaints about staff behaviour are included in ‘Staff behaviour and conduct’ on page 23). We prioritise these safeguarding complaints to assess any immediate risk or safety issues for consumers and the adequacy of actions and responses taken by the service. In 2016–17 the complaints received about people’s experiences of not feeling or being sexually safe were a catalyst for the MHCC Sexual Safety Project (for information about this project and The right to be safe project report, see the ‘Promoting service and system improvement’ section on pages 41–59).

DISCHARGE PLANNING
Concerns raised about discharge and transfer arrangements most often related to inadequate discharge planning or premature discharge. Examples of these types of issues included situations where there were identified risks to a consumer’s wellbeing and lack of consultation with families and carers about circumstances of discharge, and the types of support and follow-up that would be provided to the consumer. Other concerns related to assessing the ability of families and carers to provide support, and lack of communication or consultation prior to discharge decisions being made, including suitable discharge destinations.

These types of issues have been the subject of MHCC recommendations to services and to the Chief Psychiatrist. These recommendations highlighted the need for improved guidance on discharge planning to ensure consistency with the requirements and principles of the Act and best practice (for a summary of the Chief Psychiatrist’s work in response to this recommendation, see the ‘Promoting service and system improvement’ section on pages 41–59).

EXAMPLE COMPLAINT
Please note: names and some details have been omitted in this area, as well as the physical environment.

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

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

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

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

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

Time taken to close complaints – all complaints
In 2017–18 we dealt with 2,286 complaints (excluding enquiries), comprising 1,963 received during the year (1,636 of which were within our jurisdiction) and 323 carried forward from 2016–17. Where complaints are not within our jurisdiction, we help people to identify and access the most appropriate agency to handle that complaint. In total, 1,980 complaints were closed during 2017–18.

Forty-four per cent of all complaints were closed within one week, a further 25 per cent were closed within one month, 10 per cent within two months and six per cent within three months. The remaining 15 per cent required more than three months to close (see Figure 8). This is broadly consistent with 2016–17 and reflects the high number of oral complaints made to our office that are able to be addressed promptly through early resolution or actions taken by services, including through our staff facilitating direct resolution by services. The complexity of many of the written complaints that we receive is reflected in the complaints requiring more than three months to close.

The majority of the complaints open at 30 June 2017 (300) were written complaints in various stages of assessment, resolution or investigation. This reflects a continuing trend in the increasing cumulative total of complex complaints being dealt with by the MHCC, with a greater proportion of these matters being carried forward into the following year than in previous years.

Complaints about public mental health services
Of the 1,980 complaints closed in 2017–18, 1,672 were within the MHCC’s scope. The remainder (318) were assessed as matters that the MHCC were unable to deal with and are referred to as out-of-scope.2 These included complaints 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 primary reason that complaints were assessed as out-of-scope was because they were not about a public mental health service (89 per cent).

Of the 1,672 closed in-scope complaints, 167 were assessed as ‘resolution not applicable/possible’ (see Figure 9).

To provide an accurate picture of the work we undertake to achieve resolution outcomes in closed complaints about public mental health services, we exclude all matters assessed as ‘resolution not applicable/possible’ when reporting on these outcomes. These are complaints where we are unable to undertake resolutions actions due to the type or circumstances of the complaint. We refer to the remaining complaints as ‘in-scope for resolution’. For 2017–18 there were 1,505 complaints that were in-scope for resolution.

The most common reasons for a complaint being assessed as ‘resolution not applicable/possible’ were:

– we were unable to progress the complaint because we could not make further contact with the person who had made the complaint or the complaint was withdrawn before we could begin dealing with the complaint
– the consumer at the centre of the complaint did not consent to the complaint proceeding, and it was assessed that there were no special circumstances for accepting the complaint without consent
– the circumstances changed and no further action was required.

We provide information and assistance to address the concerns raised in all matters that come to our office. For matters assessed as ‘resolution not applicable/possible’, we provide advice and information and follow up with contacts and referrals, wherever possible.

Figure 8
time taken to close complaints
base: all complaints closed by the MHCC (n = 1,980)
2016–17

1 week 51%
1 month 73%
2 months 81%
3 months 86%
1574 total

2017–18

1 week 44%
1 month 69%
2 months 79%
3 months 85%
1990 total

Figure 9
in- and out-of-scope complaints
base: complaints closed (n = 1,980)
in-scope
1672
out-of-scope
318
in-scope – resolution not applicable
167
in-scope for resolution
1505

2 The MHCC received 327 complaints that were out of scope in 2017–18 in total, however, nine of these were still open at 30 July 2017 (to enable follow-up assistance to be provided) and are therefore not included in the closure data.
Safeguarding rights and resolving complaints

processes (detailed MHCC assessment and resolution outcomes: in-scope complaints

Figure 11 (n = 1,505)

29% partially resolved
85% not resolved
63% resolved

facilitated to the service
32% fully or substantially resolved
76% in-scope complaints

Figure 10 resolution outcomes
base: complaints in-scope for resolution (n = 1,505)

RESOLUTION OUTCOMES

We achieved positive outcomes and actions by services in 1,448 of the 1,505 closed complaints that were in-scope for resolution (96 per cent). This was achieved either:

– through our office dealing promptly with an oral complaint to support an early response and local resolution by the service (1,148 complaints equating to 76 per cent) without the need for the complaint to be confirmed in writing and formally accepted by our office, or

– by the concerns being fully or partially resolved through detailed MHCC assessment and resolution processes (300 complaints equating to 20 per cent) (see Figure 10).

Fifty-seven of the 1,505 closed complaints that were in-scope for resolution (four per cent) were not resolved. These reasons why it is not possible to achieve some positive outcome in all complaints are discussed below.

For the majority of the complaints where we facilitated early response and local resolution by the service, we engaged in a number of discussions with all parties to clarify the issues and facilitate resolution. In most instances, we provided advice to the service on ways to resolve the issues and confirmed agreed actions, answers and explanations from the service in response to the person’s concerns.

In the 357 complaints closed through detailed MHCC assessment and resolution processes (usually through formal acceptance of a written complaint), 55 per cent (196) were fully or substantially resolved, 29 per cent (104) were partially resolved and 16 per cent (57) were not resolved (see Figure 11). Where concerns were fully or partially resolved, our detailed MHCC assessment and resolution processes included reviewing records, policies and written responses and reports, and facilitating meetings between services, consumers and carers.

The 357 complaints closed through our detailed assessment and resolution processes represent a 22 per cent increase on the 293 complaints closed in this way in 2016–17. As at 1 July 2018, 300 complaints were still open and being dealt with in various stages of detailed assessment and resolution. This number of open cases reflects the continuing increase in complex complaints our office received in 2017–18. These cases require longer term action, significant follow-up with services and in some cases investigation or consideration of undertakings to ensure the quality and safety issues have been addressed.

OUTCOME DEFINITIONS

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 resolution was achieved for one or more of multiple issues raised, or partial resolution was achieved for a single issue.

Not resolved Complaints where it is not always possible to resolve complaints made to our office. Where appropriate, we provide advice and recommendations to the service or to the individual about other possible courses of action, including referral options to other bodies such as Victoria Legal Aid or community legal centres for legal advice.

THE FOUR A’S 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.

HOW COMPLAINTS WERE ADDRESSED AND RESOLVED: THE FOUR A’S

When the outcomes of the 357 complaints closed through detailed MHCC assessment and resolutions processes were categorised into the four A’s of complaints resolution, 92 per cent recorded an action outcome, 78 per cent recorded acknowledgements by the service, 61 per cent resulted in explanations or answers in relation to the issues raised and 31 per cent resulted in an apology from the service (see Figure 12).

Apologies and acknowledgements are critical elements of complaints resolution because they can help to build or restore a person’s relationship with their treating team and the service, and provide a foundation to work through other issues that may be impacting on their treatment or recovery. We continue to work with services on strengthening these important ways of resolving complaints and supporting people’s recovery.

Figure 12 outcomes of complaints: the four A’s
base: in-scope complaints closed through detailed MHCC assessment and resolution processes (n = 357)

92% action
78% acknowledgement
61% answers
31% apology
Actions were the single most common outcome of complaints to our office. Similar to last year, the most common actions taken by services to address individual concerns were:

- recognising and addressing communication issues between consumers, families, carers and services
- identifying and acting on staff training needs (for example, in gender-sensitive practice, family-inclusive practice and approaches to providing trauma-informed care)
- reviewing or developing the consumer’s treatment/recovery plan
- arranging access to a second psychiatric opinion
- providing or offering appropriate services
- making changes to infrastructure, facilities or activities.

As part of our assessment and resolution processes, we:

- listened to the concerns of consumers, families and carers to clarify and respond to issues raised
- facilitated meetings between consumers, families, carers and service providers to help achieve outcomes from the complaint
- assisted consumers, families and carers to prepare for meetings with service providers
- discussed possible ways to resolve individual complaints with service providers, including how services and supports are provided
- reviewed policies and other documents to suggest or recommend policy and practice improvements
- confirmed service improvement actions initiated by the service or made recommendations for service improvements.

Services have continued to identify opportunities for improvement and to work collaboratively with the MHCC to resolve complaints in constructive and positive ways. In 2017–18, 184 service improvements were recorded across 66 complaints. These improvements were made in some instances where a service proactively initiated an improvement after receiving the complaint, often as a result of discussions between the service and the MHCC in resolving the complaint, and also as a result of formal MHCC recommendations.

An overview of service improvements made and areas addressed in our recommendations to services is included in the ‘Promoting service and system improvement’ section on pages 41–59.

**EXAMPLE COMPLAINT**

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

Max contacted the MHCC to discuss his concerns that his medical needs weren’t adequately met during a recent inpatient admission. Max explained that he has a number of medical conditions that affect his mobility, causing him to need a wheelchair at times and help getting in and out of bed.

We worked with Max to reach an understanding of his concerns. We acknowledged Max’s right to have his medical and other health needs recognised and responded to while receiving mental health treatment. We assessed that the issues in Max’s complaint related to coordination of all aspects of his treatment and care, communication with him about his assessment and treatment and his views and preferences being sought and respected. We also assessed that there were issues about communication with other medical practitioners involved in Max’s treatment and the involvement of allied health practitioners during his inpatient admission and after Max returned home. Max’s experience also raised concerns about the physical environment of the inpatient unit and the difficulties that the layout of the ward presented for people with mobility concerns.

We talked with Max about the outcomes he was seeking from making a complaint. He said he wanted to be assured the service would improve the way they provided services to people with additional medical and physical support needs. Max said he wanted his experience to count for something and that he didn’t want someone else in a similar position to have the same experience.

After speaking with Max, we contacted the service to convey the concerns in his complaint and to seek their response. As part of this discussion, we emphasised the need for the service to ensure that people’s medical and other health needs are recognised and responded to while they are receiving mental health services. The service manager reviewed Max’s health record and spoke with the staff involved in Max’s treatment and care. It was agreed that the MHCC would facilitate a meeting so Max could talk directly with staff of the service about his experience and so the service could respond directly to his concerns.

At the meeting, the service manager apologised to Max for his experiences as an inpatient. She acknowledged areas for improvement arising from the complaint and outlined the changes the service had made since Max’s admission. These included improving internal referral processes to ensure consumers can access multidisciplinary assessment and treatment as required, and purchasing equipment and mobility aids. Changes had also been made to the way assessments are undertaken to increase the focus on physical health, mobility support requirements and environmental safety, and to the way the outcome of assessments are communicated to the multidisciplinary team and documented in the person’s health record.

Max said he had received ‘peace of mind’ from hearing about the changes the service had made and that he was relieved something good had come from making the complaint.
INVESTIGATIONS

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

When we have decided to conduct an investigation, we notify the service of this in writing. The Commissioner and any appointed investigators may request documents from the service and arrange interviews with the consumer, family members or carers as appropriate, and relevant service staff and senior management. After conducting an investigation, we then prepare a written report that details our findings and recommendations. The service then has 30 business days to provide a written response detailing the actions they have taken or will take to resolve the complaint and address the recommendations.

COMPLAINTS REFERRED TO INVESTIGATION IN 2017–18

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

INVESTIGATIONS CONCLUDED IN 2017–18

In 2016–17 we commenced four investigations about sexual safety in acute mental health inpatient units. The investigations concerned incidents of sexual safety breaches, including suspected and alleged sexual assaults. All of these incidents had devastating impacts for the women at the centre of the sexual safety complaints and their families and raised significant issues in relation to their right to be safe during their admission. The investigations involved four separate mental health services. The common terms of reference that were addressed were:

- ensuring sexual safety and safeguarding consumer rights: how this was addressed in the services’ policies and procedures, assessment of and response to risk factors including vulnerability and sexual disinhibition, admission and transfer practices and physical infrastructure
- trauma-informed care and response: whether and how trauma histories were being taken and trauma-informed care provided
- service response to sexual safety breaches: how services were responding to allegations or instances of sexual harassment, sexual activity and sexual assault, including the steps taken to re-establish safety, the support provided to notify family, carers and police (where appropriate), the provision of counselling support and discharge planning
- incident notification, investigation processes and complaints management: how sexual safety breaches were being reported and investigated internally and how the services were managing related complaints made directly to them and to our office.

We concluded these investigations in 2017–18 and then provided the services with reports documenting our findings and recommendations. Our recommendations in each of the investigations concern a range of issues such as:

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

In response to the findings and recommendations of these investigations, we received and reviewed detailed action plans from each service to address specific issues and for broader service improvements relating to sexual safety. Taking into account the gravity of the issues identified in the investigations, we assessed that the responses to the findings and recommendations by services demonstrated clear commitments to undertake actions to address the critical issues of sexual safety within their respective services.

We have been working with the services to ensure the actions they had identified are implemented effectively, including supporting the development of plans for auditing and reporting on these actions, both internally and to the MHCC. At the conclusion of all investigations we also work with the consumer and their family, where the family has participated in the complaint and investigation, to determine whether the investigation addressed each of their individual concerns and experiences and, if appropriate, to discuss additional resolution options.

The findings from each of these investigations have been confronting for all concerned. They have reinforced the significant role that investigations can play in safeguarding people’s rights and identifying critical issues and gaps in service practices and environments.

The proactive approach of the services to addressing the issues identified in the investigations has been encouraging, with service improvements being implemented by each of the four services before our recommendations had been finalised. Since receiving our investigation reports, there has been broad acceptance of our recommendations, with the services advising the MHCC of their commitment to effecting the changes. In 2018–19 we will continue to work with the services to explore the critical complaints resolution options that acknowledge and address the experiences and concerns raised in each complaint.

OUR PRIORITIES

As part of our practice review, we will continue to develop our practices to improve the timeliness and effectiveness of our work in resolving complaints. We aim to ensure that our approaches are supportive, comprehensive and ensure people’s safety in mental health services, with a continuing focus on ensuring sexual safety and addressing other safeguarding issues. We aim to increase the ability of services to identify issues affecting people’s rights, and to hold services accountable for promoting and upholding the rights of consumers, families and carers. We will continue to work with services to identify areas for further improvement and to recognise the many instances of improvements that occur through proactive service action.
LOCAL COMPLAINTS REPORTING

Amelie told us that she wanted to try to resolve her concerns directly with the service, and we advised the service of Amelie’s concerns and what she was seeking as an outcome of the complaint.

Drawn from Amelie’s complaint on page 19.

OUR ROLE

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

OUR APPROACH

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

Data obtained through local complaints reporting was a key source of information for the MHCC Sexual Safety Project (see pages 46–53). Having identified complaints that raised concerns in relation to sexual safety, we made an additional request to services for complete data on the outcomes of these complaints. Responses to this request provided valuable insights into the actions taken in response and identified key areas for service improvement. These included the need for improved approaches to reporting suspected and alleged sexual assaults to Victoria Police and supporting people to access appropriate counselling services, including Centres Against Sexual Assault, following a suspected or alleged sexual assault.

This process highlighted the value and importance of receiving outcome data as part of the local complaints reporting process. We will continue to work with services to improve reporting of outcomes and with the department on key requirements of future data collection and reporting platforms. In the interim we will continue to request additional information in this manner where we identify themes and common issues in reported complaints, particularly when risk and safeguarding issues are raised.

Last year we distributed individual complaints reports to mental health services for the first time. These reports analysed complaints reported by services and those made directly to the MHCC to provide a statewide comparison of complaints as well as commentary tailored for each service. In 2017–18 we reviewed the template used to create these reports to simplify and make the reports accessible to a broader audience within services for identifying quality and safety issues and informing service improvements.

In this annual report we are reporting on a financial year rather than a calendar year for the first time to better align with other reporting undertaken by services. In early 2018–19 we will distribute individual service provider reports about 2017–18 complaints to services and make available on our website a report comparing statewide trends in MHCC and local complaints for 2017–18. We will continue to meet with mental health services about themes from these reports in the coming year.
A NOTE ABOUT THE DATA IN THIS SECTION

Caution should be used when interpreting the data from complaints reported by services because it may not represent 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 (‘in-scope’ reported complaints). We have endeavoured to remove all complaints that were made directly to the MHCC without first being made to the service to avoid counting complaints twice. However, due to differences in data entry practices at services, it is possible that a small number of complaints reported by services were not clearly identified as complaints that were made through notification from the MHCC.

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

OBSERVATIONS ABOUT THE DATA

Overall, complaints reported by services were notably higher in 2017–18 than in 2016 and were more consistent with the number of complaints reported in 2015. As in previous reporting periods we continued to observe significant issues in relation to data collection. Considerable work was required by the MHCC to produce a consistent, combined dataset that would enable meaningful data analysis.

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

CONTRIBUTIONS TO THE DEVELOPMENT OF A FUTURE COMPLAINTS REPORTING PLATFORM

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

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

OVERVIEW OF COMPLAINTS REPORTED BY SERVICES

This overview provides a comparative analysis of data from complaints made to services and to the MHCC for the period 1 July 2017 to 30 June 2018. It compares numbers, service types, issues and sources of complaints.

Given the short timeframe between receiving local complaints data and finalising this report, analysis of complaints outcomes will be included in the statewide report on complaints trends to be published in 2018–19.

We note that reporting on complaints outcomes has historically been low (between 20 and 26 per cent of all reported complaints). We will continue to seek to address this with services, as they are required under the Act to include this information in their complaints reports to the MHCC.

This year we achieved a 58 per cent compliance rate, with 58 of the 59 services that provide public mental health services in Victoria submitting a complaints report to the MHCC. This is only a very slight decrease from the 100 per cent compliance achieved in 2016 despite the significantly shorter timeframe for services to submit data due to our move to financial year reporting. It is expected that we will achieve full reporting compliance by the time the statewide analysis of complaints trends is published.

3 For the 2016–17 annual report, the local complaints report was based on a 2016 calendar year rather than a financial year.

4 Fifty-four organisations (91 per cent) submitted complaints data in time to be included in the analysis in this report.

5 In previous reports we have reported on the percentage of total complaints reported by services that were made via the MHCC rather than removing these from the dataset before analysis (for example, of the 1,341 complaints reported by services in 2016, five per cent of this total number were complaints made originally to the MHCC). The actual increase in in-scope reported complaints is therefore closer to 34 per cent.
Local complaints reporting with MHCSS. A total of 1,476 reported complaints (87 per cent) were from designated mental health services, with 226 (13 per cent) from MHCSS.

There was an increase of 34 per cent in overall reported complaints by designated mental health services from 1,099 in 2016 to 1,476 in 2017–18. The total complaints reported by designated mental health services appears similar to 2015 (1,467), though in reality, more complaints were reported in 2017–18 because the 2017–18 total excludes complaints made via the MHCC. Complaints reported by MHCSS decreased by seven per cent from 242 in 2016 to 226 in 2017–18.

COMPLAINTS PER 1,000 CONSUMERS

Comparing the number of complaints made with 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 preliminary data provided to the MHCC, there were 73,097 consumers of designated mental health services.6 There was an average of 20 complaints per 1,000 consumers of designated mental health services compared with an average of 22 complaints raised directly with the MHCC. This reflects a slight increase on 2016 (average of 17 complaints per 1,000 consumers of designated mental health services compared with an average of 20 complaints raised directly with the MHCC).

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

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 where the complaints issues could be determined.7 In light of many complaints having more than one issue, frequency percentages do not equal 100 per cent.

The four most common issues raised in reported complaints related to staff behaviour or conduct issues (raised in 32 per cent of complaints), issues about the environment and management of the mental health facility (26 per cent), followed by concerns about communication, consultation and information (20 per cent) and treatment (20 per cent). This represents:

- an increase in the number of issues reported about staff behaviour and conduct (28 per cent in 2016), which were most commonly about perceived rudeness or a lack of empathy and sensitivity by staff
- an increase in issues reported about the environment and management of the facility (22 per cent in 2016), which were most commonly about a lack of satisfaction with the physical environment of the facility
- a significant decrease in issues reported about treatment (29 per cent in 2016), which were most commonly about a concern that treatment provided was not effective or sufficient
- an increase in concerns about communication and information, which were most commonly about a lack of involvement of the consumer, family member or carer in decision making, or a lack of information being provided.

In contrast, 71 per cent of complaints made to the MHCC included concerns about treatment issues, with communication issues the next most common area of concern (raised in 53 per cent of complaints), followed by concerns about staff behaviour or conduct (28 per cent) and medication (25 per cent). These differences in the proportions and types of complaints made to services and to the MHCC are broadly similar to those identified in the analysis of previous rounds of complaints reporting. However, the broad and increasing gap between complaints to the MHCC and those made directly to services that include concerns about treatment is concerning because it is expected that people would be encouraged and supported to raise any concerns about their treatment as part of their discussions with their treating team. It is not clear whether these concerns are not being recognised as complaints by services or whether people are not feeling confident to raise these types of concerns directly with services. These questions continue to inform our education and engagement work with services.

It is worth noting that there are some differences in the main issues reported by designated mental health services and MHCSS, reflecting the different nature of the services provided. For designated mental health services, the most significant issues were staff behaviour and conduct (28 per cent of all issues), personal safety and management of the facility (28 per cent), treatment (21 per cent) and communication and consultation issues (18 per cent). For MHCSS the most significant issue reported was staff behaviour and conduct (57 per cent of all issues), followed by communication and consultation issues (31 per cent) and access (21 per cent).

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

---

6 The number of consumers accessing designated mental health services in 2017–18 is preliminary and is therefore subject to change. The number of consumers accessing MHCSS for this period was not available at the time of finalising this report. Analysis of the proportion of complaints compared with the number of people accessing designated mental health services and MHCSS, and analysis of complaints per 1,000 consumers for MHCSS, could not be included in this report. This will be included in the statewide report on complaints reported by services and those made to the MHCC that will be available via the MHCC website in early 2018–19.

7 A small number of the complaints reported to the MHCC contained insufficient data for the complaints issues to be classified (no complaint summary, no issues categories reported). The number of complaints where issues could be identified was 1,685.
PROMOTING SERVICE AND SYSTEM IMPROVEMENT

Hana and her mother Mariam wanted to know that making a complaint had made a difference to the processes and procedures in the inpatient unit to ensure the sexual safety of all consumers admitted there.

Drawn from Mariam’s complaint on page 54.

Local complaints data is an essential source of information for our oversight role of identifying quality and safety issues in complaints and making recommendations for service improvement. It enables us to work with services to identify areas requiring attention and improvement.

In 2018–19 we will trial our new report template with services and seek their feedback on further changes or improvements that would be helpful.

We will continue to work with mental health services, the department and VAHI on refining complaints reporting systems and processes to enable us to maximise the value of the information gained and to identify and take action on areas that raise safeguarding issues.

SERVICE PROGRAM TYPES

Complaints reported by services were most commonly about adult mental health services (70 per cent), an increase from the 62 per cent of reported complaints about these services in 2016 but lower than the 78 per cent of complaints to the MHCC that were about adult mental health services in 2017–18.

Eight per cent of all reported complaints were about child and youth mental health services (CYMHS) or child and adolescent mental health services (CAMHS), a significant decrease from the 12 per cent of all reported complaints in 2016. This also indicates a lower proportion of complaints being made about CAMHS/CYMHS relative to the proportion of all consumers accessing these services (11 per cent).

Complaints reported about aged mental health services increased slightly from five per cent of all reported complaints in 2016 to six per cent in 2017–18, which is consistent with the six per cent of all consumers accessing these services.

As noted above, complaints reported by MHCSS decreased from 18 per cent of complaints in 2016 to 13 per cent in 2017–18.

In 2017–18 reported complaints were predominantly about inpatient services (56 per cent), with 33 per cent about community-based services (including MHCSS), nine per cent about other services (including mental health services provided in emergency departments) and two per cent about residential services (including prevention and recovery care services and community care units). This is a change from 2016, where complaints were more or less evenly divided between inpatient and community services.

PEOPLE WHO MADE COMPLAINTS

The proportion of complaints made by consumers continues to be higher for complaints to the MHCC compared with complaints reported by services. Consumers made 69 per cent of reported complaints compared with 74 per cent of MHCC complaints. The proportion of reported complaints made by consumers, however, slightly increased from the 64 per cent of reported complaints in 2016. Family members or carers made 25 per cent of reported complaints compared with 21 per cent of MHCC complaints, which was consistent with 2016. The remaining complaints were made by friends, advocates or legal representatives, or other service providers.

OUR PRIORITIES

Local complaints data is an essential source of information for our oversight role of identifying quality and safety issues in complaints and making recommendations for service improvement. It enables us to work with services to identify areas requiring attention and improvement.

In 2018–19 we will trial our new report template with services and seek their feedback on further changes or improvements that would be helpful.

We will continue to work with mental health services, the department and VAHI on refining complaints reporting systems and processes to enable us to maximise the value of the information gained and to identify and take action on areas that raise safeguarding issues.
Our role and approach

The Mental Health Complaints Commissioner (MHCC) has broad functions under the Mental Health Act 2014 (the Act) to identify, analyse and review quality, safety and other issues arising out of complaints, and to provide advice and make recommendations for service and system improvements.

Our office plays a key role in identifying critical issues of safety and quality from people’s experiences of mental health services, with a priority focus on addressing risks and breaches of people’s rights. Our team works with focus, commitment and in collaboration to effect positive change, ensuring the information we gain from complaints leads to improvements in the quality and safety of mental health services. In the work that we do, listening to the voice and views of people making complaints, and of their family, carers and support people, is essential to identifying ways to improve people’s experiences of mental health services.

In 2017–18 we identified many examples of mental health services proactively identifying areas for improvement and making changes to their processes, practice or infrastructure after being contacted by the MHCC. In many instances service improvements were made as a result of discussions between the service, the person who raised their concerns and our office in assessing and resolving the complaint. Many service improvements were also the result of formal MHCC recommendations.

Service improvements and recommendations

In 2017–18 the MHCC recorded 184 service improvements across 66 complaints and four investigations, more than double the number of service improvements recorded in 2016–17.

Of the 184 service improvements, most related to a review of service practices (66), changes to policies and procedures (47) and training or feedback provided to staff (46) (see Figure 14). Other improvements (25) related to changes to infrastructure, repairs or maintenance and, in two instances, identification of the need for changes to staffing profiles to respond to a particular need or to lead the implementation of systemic changes.

In 2017–18 the MHCC also made 113 formal recommendations, 57 of which were made through the resolution of complaints and 56 through investigations about issues of sexual safety in acute mental health inpatient units. Many of these recommendations resulted in the service improvements noted above. However, some recommendations, particularly those made through investigations, are complex and require 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 2018–19.

Recommendations made in investigations relating to issues of sexual safety informed the MHCC’s broader recommendations to the Department of Health and Human Services, the Chief Psychiatrist and mental health services in our Sexual Safety Project report, The right to be safe (see pages 46–53). These are in addition to the recommendations and service improvements described on pages 43–45.

Figure 14

<table>
<thead>
<tr>
<th>Service Improvements</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to service practices</td>
<td>184</td>
</tr>
<tr>
<td>Changes to policies/procedures</td>
<td>47</td>
</tr>
<tr>
<td>Training/feedback to staff</td>
<td>46</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
</tr>
</tbody>
</table>
Staff training

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

- family-inclusive practice
- gender-sensitive and trauma-informed practice
- identifying and responding to complaints
- rights and responsibilities under the Act, including the requirement to provide and explain the statement of rights, and people’s right to make an advance statement and elect a nominated person
- restrictive interventions, including training that addresses de-escalation and prevention strategies as well as the requirements of legislation and relevant guidelines where restraint or seclusion are used
- identifying and responding to individual needs, including physical health needs
- the appropriate use of bariatric equipment
- incident reporting requirements
- internal processes including referral and discharge processes
- responsibilities under the Act and Charter of Human Rights and Responsibilities Act 2006 to ensure that rights, dignity and autonomy are respected and promoted.

Other improvements

The remaining improvements and recommendations primarily concerned changes to infrastructure, for example:

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

Policies and procedures

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

- improvements to discharge planning such as:
  - reviewing handover processes to ensure community teams have confirmed acceptance of referrals before a person is discharged from the inpatient unit
  - ensuring communication occurs with general practitioners or other community supports
  - ensuring services seek the consumer’s consent at several points during their inpatient admission to engage with their family, carer or other support person, and implementing processes to ensure this occurs
  - reviewing gender-sensitive policies and associated procedures, including developing new tools and processes to assist staff in responding appropriately to alleged sexual safety breaches
  - reviewing policies and procedures associated with the use of restrictive interventions to reflect the Chief Psychiatrist guidelines, particularly in relation to the use of prone restraint and restraint for older people or people with existing medical conditions, and ensuring that clinical and security staff are aware of the requirements of these guidelines
  - reviewing admission processes for acute mental health inpatient units to ensure any need for additional support is identified (for example, disability support, use of mobility aids or supports for physical health needs including medical devices and access to allied health supports)
  - reviewing complaints policies and procedures to ensure consumers, families and carers can easily provide feedback
  - developing formal processes to support and enhance the provision of shared care with private practitioners
  - reviewing policies about access to mobile phones and personal electronic devices in acute mental health inpatient units
  - reviewing policies about supporting compulsory patients to access the Second Psychiatric Opinion Service
  - reviewing policies and practices to ensure staff have clear guidance about the requirements of the Act to provide statements of rights and relevant orders under the Act
  - reviewing policies in relation to searches of property.

- policies and procedures associated with the use of restrictive interventions to reflect the Chief Psychiatrist guidelines, particularly in relation to the use of prone restraint and restraint for older people or people with existing medical conditions, and ensuring that clinical and security staff are aware of the requirements of these guidelines
- reviewing admission processes for acute mental health inpatient units to ensure any need for additional support is identified (for example, disability support, use of mobility aids or supports for physical health needs including medical devices and access to allied health supports)
- reviewing complaints policies and procedures to ensure consumers, families and carers can easily provide feedback
- developing formal processes to support and enhance the provision of shared care with private practitioners
- reviewing policies about access to mobile phones and personal electronic devices in acute mental health inpatient units
- reviewing policies about supporting compulsory patients to access the Second Psychiatric Opinion Service
- reviewing policies and practices to ensure staff have clear guidance about the requirements of the Act to provide statements of rights and relevant orders under the Act
- reviewing policies in relation to searches of property.
THE MHCC’S SEXUAL SAFETY PROJECT

Sexual harassment and sexual assault are violations of people’s human rights that can cause immeasurable trauma and, along with other types of sexual safety breaches, are significant avoidable harms that must be addressed.

All people have the right to feel and be sexually safe when accessing acute mental health inpatient treatment, and mental health services have clear obligations to ensure a safe environment and people’s sexual safety.

It is clearly unacceptable that people can become victims of sexual harassment and sexual assault, or experience other breaches of their sexual safety, during an admission to an acute mental health inpatient unit. The right to be safe report sets out the detailed recommendations on the actions required to address the significant issues identified in complaints about sexual safety breaches.

Commissioner Lynne Coulson Barr

Project background

Over the MHCC’s first three years of operation to 30 June 2017, we identified concerning themes in complaints about sexual safety in mental health services. These included complaints about people not feeling or being sexually safe or experiencing sexual activity, sexual harassment or alleged sexual assault in acute mental health inpatient environments. While the nature of these complaints varied, the gravity of many of the issues raised and the variability in service responses indicated a need for closer examination of these issues to identify ways to prevent these significant avoidable harms.

Accordingly, in 2016–17, our office commenced the MHCC Sexual Safety Project. Our aim was to review issues of sexual safety in acute mental health inpatient environments as part of carrying out our functions under the Act to identify, analyse and review quality, safety and other issues arising from complaints or concerns; and to provide advice to mental health service providers on any matters relating to a complaint (s 228 (e)). Specifically, we sought to examine the circumstances that contribute to consumers feeling or being sexually unsafe, and to consider best practice approaches for ensuring sexual safety.

Our project findings and the recommendations made to the Department of Health and Human Services, the Chief Psychiatrist and mental health services are detailed in the project report, The right to be safe. We launched this report at our inaugural learning from complaints forum (see pages 52–53).

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

Commissioner Lynne Coulson Barr
RECOMMENDATIONS FOR ENSURING SEXUAL SAFETY

In The right to be safe report we identified the need for sexual safety to be recognised as a human rights issue and to receive priority attention in accordance with Victoria’s broader violence prevention strategies. The report’s recommendations to the Department of Health and Human Services, the Chief Psychiatrist and mental health services are summarised below.

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

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

This strategy should draw together and build on the foundations established in existing approaches to sexual safety to:
– address leadership and governance issues including establishing clear reporting and monitoring mechanisms to better identify and respond to sexual safety breaches
– support services to implement trauma-informed care and supported decision making as primary prevention strategies to prevent sexual safety breaches
– develop and implement clear minimum infrastructure requirements to support sexual safety in mixed-gender environments, and pilot and evaluate single-gender units, prioritising the piloting of women-only units
– provide clear guidance to mental health services about investigating and reporting sexual safety breaches to ensure people accessing mental health services receive responses that are consistent with those in other service settings.

The data analysis undertaken for this project revealed that the majority of complaints related to breaches of women’s sexual safety by male co-consumers, and that there were a number of risks in acute mental health inpatient units, particularly in intensive care areas, that need to be addressed to uphold all people’s right to safety in these environments.

The right to be safe report highlights that people accessing acute mental health inpatient treatment are generally experiencing a significant crisis in their lives and are acutely unwell. Services have a duty to all people to prevent both the harm associated with any breach of sexual safety and the potential ramifications for a person identified as an alleged perpetrator.

The report notes that the sexual safety risks to men in these environments also need to be better understood, along with the issues experienced by younger and older people, people with disabilities, LGBTI people and people from culturally and linguistically diverse communities (for the full project data analysis and findings, access The right to be safe report at www.mhcc.vic.gov.au/resources/publications).

Despite the clear gaps and areas for significant improvement that we identified, the report also acknowledged the range of initiatives and genuine efforts made over time by mental health services, successive governments and the Department of Health and Human Services to improve safety in acute mental health inpatient environments.

It’s almost impossible to ensure women’s safety, but we are starting to have conversations around a women-only ward … it has so many benefits. It’s certainly worth pursuing and giving a trial.”

Mental health service staff member

If I could have it the way I want it, I would have in every mental health service split wards – one female ward and one male ward.”

Woman who made a complaint

The Mental Health Complaints Commissioner Annual Report 2018

100+ people consulted, including:
– people with lived experience, families and carers
– service providers and staff
– professional bodies, peak bodies, government and advocacy organisations

90 complaints analysed

200+ pieces of research, grey literature, policy and standards reviewed

3700+ pages of clinical records reviewed

170+ pages of complaint, investigation and incident-related documents reviewed

1200+ pages of services policies, guidelines, training resources, handouts and posters reviewed

54 interviews associated with investigations conducted with people accessing services, families and carers, and mental health service staff
Goverance
Establish clear reporting and monitoring mechanisms to ensure accountability for preventing sexual safety breaches.

Leadership and service cultures
Ensure leadership supports best practice in preventing and responding to sexual safety breaches. This is essential to ensure people are and feel safe in acute mental health inpatient units. This includes establishing shared, rights-based understandings of the reasons for preventing sexual activity in these environments and ensuring all staff are able to recognise, clearly name and respond to breaches of sexual safety, particularly incidents of sexual harassment and sexual assault.

Organisational, workforce and practice development – trauma-informed care
Implement trauma-informed care as a primary prevention strategy in recognition of the prevalence of trauma among people accessing acute mental health inpatient services and the re-traumalisng impacts of sexual safety breaches.

Infrastructure and design
Ensure unit planning, design and maintenance supports sexual safety, with a particular focus on responding to the needs of women and vulnerable consumers.
Pilot and evaluate single-gender units, with a priority on piloting women-only units, and consider ways in which all inpatient units can be designed or adapted to provide additional flexible areas to meet the needs of varying inpatient populations, including trans or gender-diverse people.
Develop a plan to improve the safety of intensive care areas and develop alternative strategies for supporting people who are vulnerable and at risk in these environments.

Orientation to the inpatient unit
Ensure orientation includes working with the person to identify what will help them to feel safe, as well as clarifying that sexual activity is unacceptable, outlining how they can seek support from staff if they are feeling unsafe, and the response that can be expected when concerns are raised about sexual safety.

Risk assessment and management
Create a common framework to ensure risk assessments consistently identify and respond to environmental, perpetrator and vulnerability factors, and work jointly with people accessing inpatient treatment to identify and manage risk.

Trauma-informed care
Develop tiered approaches to implementing trauma-informed care to ensure mental health service staff with the appropriate skills and capabilities lead responses to sexual safety breaches, and ensure pathways to trauma-specific care are clear and available.

Open disclosure
Develop specific guidance and approaches for managing open disclosure in relation to sexual safety breaches, ensuring cultural, religious, communication and other needs are responded to, and staff are supported in conducting open disclosure.

Reporting sexual safety breaches to Victoria Police
Develop clear guidance on the duty of services to report a suspected or alleged sexual assault to Victoria Police, consistent with other service settings.

Working with Victoria Police to respond to sexual safety breaches
Develop clear policy and guidance for mental health services in collaboration with Victoria Police on responding to sexual safety breaches, including preservation of evidence, documentation, reporting and review mechanisms.

Investigation standards
Develop clear policy and guidance on the thresholds and requirements for investigations and other review processes and consider external oversight of decision making about the necessary level of review of suspected or alleged sexual assaults, consistent with the requirements of other service settings.

Incident reporting
Ensure reporting mechanisms and requirements are consistent with standards required in other service settings, including that breaches of sexual safety are escalated for internal review.
Ensure these mechanisms and requirements are integrated and allow for patterns in reported incidents to be identified for quality improvement.

Documentation
Ensure observations or reports are clearly and accurately recorded at the time of the incident using factually accurate terms to describe the nature of any sexual safety breaches.

Discharge planning and referrals
Ensure discharge planning clearly identifies the nature of any breach experienced, as well as planning for future admissions, outlining necessary support and referral for the person, their family and carers.

Each area of recommendation outlined above contained a number of sub-recommendations to the department (42), the Chief Psychiatrist (10) and mental health services (50). These recommendations are in addition to the recommendations made through individual complaints and investigations, and are systemic in nature.

In addition to these recommendations, the report identifies the need for a cohesive approach to implementation that measures, monitors and responds to trends in sexual safety breaches and identifies areas requiring support and intervention. Implementing many of the project recommendations will be a long-term endeavour. The report identifies actions that the department, the Chief Psychiatrist and mental health services can implement immediately and over time to ensure the sexual safety of all people accessing acute mental health inpatient treatment in Victoria.

In response to The right to be safe report, the Department of Health and Human Services has agreed to develop a comprehensive sexual safety strategy that responds to the recommendations, and to drive an implementation plan to ensure a continued and sustained commitment across all mental health services (for the department’s full response, see page 9 of The right to be safe report and for an update, see page 53).
OUR INAUGURAL LEARNING FROM COMPLAINTS FORUM ON SEXUAL SAFETY

On 23 March 2018 we held our inaugural learning from complaints forum on complaints and avoidable harms – ensuring sexual safety in acute mental health inpatient units. This was an opportunity for us to explore key themes identified in the Sexual Safety Project and to mark the launch of The right to be safe report.

Attendees from across the sector came together to consider our recommendations relating to practices, guidelines, infrastructure, training and culture, and to explore the range of perspectives and partnerships required to address this significant avoidable harm.

Highlights from the day included:

– poet and author Ms Sandy Jeffs opening the forum with her poem ‘McMadness #2’, reflecting on her experiences of and aspirations for the mental health system
– Commissioner Lynne Coulson Barr and Deputy Commissioner at the time of the project Ms Bee Mitchell-Dawson discussing the project findings and recommendations, and the implications for mental health services
– the Department of Health and Human Services’ Dr Margaret Grigg delivering the department’s response
– a message from the Minister for Mental Health, the Hon Martin Foley MP communicating the government’s commitment to develop a comprehensive sexual safety strategy in response to the report’s recommendations
– National Mental Health Commissioner and former Commissioner on the Royal Commission into Institutional Responses to Child Sexual Abuse Professor Helen Milroy sharing key learnings from the royal commission on the prevalence and impacts of trauma for people accessing mental health services and risks of re-traumatisation through breaches of sexual safety
– Director of Monash Alfred Psychiatry research centre Professor Jayashri Kulkarni putting forward key considerations from the literature and research.

[The complaints process] has provided me with a great sense of relief at the prospect that I was not only believed but taken seriously. The work that has been done and that is continuing to be done will see changes made and hopefully prevent what happened to me happening to another woman.”

Consumer who participated in one of the investigations about sexual safety

Feedback we received

We received positive feedback from attendees who responded to our survey on the forum, which included the following:

84% of respondents found the forum ‘excellent’ or ‘very good’

96% found the speakers engaging and knowledgeable

88% found the forum a good way to communicate what can be done to ensure sexual safety in acute mental health inpatient units

96% said their understanding of sexual safety and appropriate responses to breaches had improved

88% said the forum had helped them to identify actions that they could implement in their workplace to ensure sexual safety

Respondents told us that they appreciated the robust research, the balanced information presented, hearing from diverse speakers including consumers, and the honesty and commitment to change that was demonstrated.

Presentations and panel sessions included representatives from the department, the Office of the Chief Psychiatrist, the Victorian Mental Illness Awareness Council (VMIC), Tandem Carers, Women’s Mental Health Network Victoria and Victorian public mental health services. The forum also included representatives from the Office of the Public Advocate, the Victorian Equal Opportunity and Human Rights Commission, the Australian Commission on Safety and Quality in Health Care, Transgender Victoria, Victoria Police and Centres Against Sexual Assault.

This forum was an important step towards creating a shared understanding of the issues associated with breaches of sexual safety and achieving a shared commitment to preventing these significant avoidable harms and breaches of rights in mental health services.

OUR FOLLOW-UP TO THE RIGHT TO BE SAFE

Since the release of The right to be safe report, we have been engaging with the department, the Chief Psychiatrist and mental health services to further our understanding of their responses to the recommendations and to discuss the actions that are being taken to ensure sexual safety. We are encouraged by the positive and proactive responses of many services to date. Our team has also been engaging with consumer and carer organisations and networks on the implications of the report’s findings, including VMIC and members of the National Register of Mental Health Consumer and Carer Representatives and the National Mental Health Consumer and Carer Forum.

Our planned activities include furthering these discussions, as well as:

– delivering training sessions to mental health staff on ensuring sexual safety, including nurses working in mental health as part of the Western Victorian Mental Health Learning and Development Cluster program
– continuing to develop the MHCC’s approaches to addressing sexual safety issues identified in complaints through complaints assessment, resolution and investigation and through reviewing complaints data
– including the report’s findings and recommendations in materials used to support our work in education and engagement, and contributions to consultations and submissions relating to broader areas of service and system improvement
– seeking formal responses from the department, the Chief Psychiatrist and mental health services on the actions that have been taken and planned to respond to the report’s recommendations.

We will continue our discussions on ways to address and prevent these significant avoidable harms in Victoria’s acute mental health inpatient units in 2018–19.
EXAMPLE COMPLAINT
Please note: names and some details have been omitted in order to protect the identity of those involved.

Mariam contacted our office to discuss her concerns about the sexual safety of her daughter, Hana, who had been admitted to an inpatient unit. Mariam said she was concerned about her daughter being admitted to a mixed-gender unit because of Hana’s history of trauma. When assessing a complaint with sexual safety concerns, the MHCC considers applicable guidelines as well as services’ responsibilities under relevant quality and safety standards, the Act and the Charter. Mental health services are required to take all reasonable steps to protect people’s physical, sexual and emotional safety while responding to their particular needs, experiences and preferences. Relevant guidelines, standards and the mental health principles all provide guidance to services, outlining considerations in providing a safe and supportive environment.

For a complaint that is made by a family member or carer to progress, the Act requires the MHCC to seek the consent of the consumer at the centre of the complaint. We contacted Hana to discuss the concerns her mother raised with us, and Hana gave consent for the complaint to proceed and for our office to contact the service. Hana also told us that some of the male consumers had been following her around and making comments to her that made her feel uncomfortable and unsafe, including comments about her appearance and whether she was interested in ‘hooking up’. Hana told us that she had already raised this with more than one nurse but she did not feel she was taken seriously. Hana told us that she was told to stay away from those consumers, and no further action had been taken.

After speaking with Mariam and Hana, we assessed that their complaint raised immediate concerns about Hana’s safety and required immediate contact with the service to ensure action would be taken to address these concerns. Accordingly, we conveyed Mariam and Hana’s concerns to the manager of the inpatient unit and asked her to meet with Hana to seek her views about what support she would need to feel and be safe during her admission. As soon as the manager was advised of the concerns, she met with Hana and made arrangements to provide her with this support. This included moving Hana to the women-only corridor and outlining steps she could take to ensure her own safety, including how to lock her bedroom door and how to seek further help or support from staff if needed. The manager also assured Hana that she would speak with the consumers Hana had identified about expected standards of behaviour and require staff to actively manage the risks to her and other female consumers.

While the manager addressed Hana’s immediate safety concerns, we assessed that this complaint raised systemic concerns about how the service managed sexual safety in an acute inpatient environment. In particular, we were concerned that Hana’s history of trauma and the impact that this would have on her experience of mixed-gender inpatient treatment hadn’t been identified as relevant or responded to in her treatment planning before we contacted the service. We were also concerned that Hana had spoken to staff about comments made by other consumers that made her feel uncomfortable and unsafe but that these concerns hadn’t been adequately responded to. We spoke with Mariam and Hana about formalising their concerns in writing to enable the MHCC to confirm with the service that changes had been made in response. Although Hana had now returned home, Hana and her mother agreed to this because they wanted to know that making a complaint had made a difference to the processes and procedures in the inpatient unit to ensure the sexual safety of all consumers admitted there.

Mariam confirmed her concerns in writing, and we wrote to the service to advise of this and to ask for information about any recently implemented proposed improvements to their inpatient unit policies and procedures. We also asked the service to specifically advise us about how they ensure they respond to trauma as part of treatment planning, and expected responses to reported or observed sexual harassment in the inpatient environment.

Following a number of discussions with the service, a senior staff member advised of changes to orientation procedures for consumers that included ensuring people are asked about what would help them feel safe during their admission, explaining ways that staff can support people to feel safe, and working with the person to develop a treatment plan that responds to their individual needs and preferences. The staff member explained that this conversation provides an opportunity to ensure that people can let the service know what is important for them to be and feel safe during their admission without asking specifically about their trauma history at an already distressing period. As part of orientation, the service also ensures people know how to seek help if they feel unsafe at any time.

The staff member also advised that the service had provided training to all staff about their responsibilities if someone was to report sexual harassment, including reiterating the right of all consumers to safety and the responsibility of all consumers and staff to treat each other respectfully. The service also advised that reports of sexual harassment should prompt a review of sexual safety risk assessments and any action that may be required to ensure the safety of all consumers accessing treatment.

The service spoke with Mariam to convey these changes and thanked her for bringing her concerns to their attention. Mariam spoke with Hana about the information the service had provided and they both said they were satisfied with the outcome. We also assessed the service’s response against the requirements and principles of the Act, relevant guidelines and standards and were satisfied that the service had taken reasonable steps to address the concerns raised in this complaint. Mariam thanked our office for addressing the issues raised in her complaint and resolving her and Hana’s concerns in ways that led to tangible changes at the service.

The issues of sexual safety that we identified in Mariam’s complaint, and in other complaints raised by consumers, families and carers, led us to undertake the MHCC Sexual Safety Project, with the aim of ensuring the sexual safety of all Victorians accessing acute mental health inpatient treatment (for more information on this project, see pages 46–53).
CONTRIBUTIONS TO CONSULTATIONS, PROJECTS AND ADVISORY GROUPS

We contributed the knowledge we have gained through hearing and responding to people’s experiences of mental health services by taking part in a wide range of sector consultations, forums and other activities. Participating in these activities 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.

In 2017–18 we provided input into 31 key projects and consultations including:

- input into the development of Chief Psychiatrist guidelines, including guidelines on the use of electronic devices in acute mental health inpatient units, the use of surveillance in acute mental health inpatient units and discharge planning
- providing advice on various policy and legislative reforms, including on planned reforms to information-sharing frameworks and provisions, transition to the National Disability Insurance Scheme (NDIS), and consultation on treatment options for people with complex needs including mental illness and drug addiction
- contributions to the development of complaints handling, mediation and conciliation standards
- input into the development of educational materials and research projects, including the University of Melbourne’s Master of Psychiatry online teaching materials
- input into the planning processes for a number of organisations including the Victorian Auditor-General’s Office, the Victorian Institute for Forensic Mental Health (Forensicare), the Victorian Agency for Health Information and Women’s Mental Health Network Victoria.

We also participated in four key advisory and reference groups to support related areas of work. These are the:

- Office of the Chief Psychiatrist Human Rights Project Advisory Group
- Safer Care Victoria Project Group on Targeting zero recommendations – information-sharing provisions
- Culturally and Linguistically Diverse Communities Grants Advisory Group – joint Victorian Mental Illness Awareness Council and Tandem Carers project
- Department of Health and Human Services Progress Measures Working Group.

Further information about our contributions is provided in Appendix 1 (see pages 74–76).

SUBMISSIONS AND REPORTS

In 2017–18 we provided formal feedback on seven matters. These were the:

- Department of Health and Human Services proposals for alternative arrangements for managing violent and aggressive behaviour
- Office of the Chief Psychiatrist draft mental health intensive care guidelines
- Royal Australian and New Zealand College of Psychiatrists position statement on supported decision making
- Statutory Duty of Candour Targeting zero recommendations – response to the consultation paper
- Victorian Ombudsman draft good practice guide to dealing with challenging behaviour
- NDIS Quality and Safeguards Commission market oversight – response to the consultation paper
- NDIS Quality and Safeguards draft rules legislation.

PARTICIPATION IN NATIONAL MEETINGS

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

RECOMMENDATIONS MADE TO THE SECRETARY TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

In 2017–18 our detailed recommendations to the department and the Office of the Chief Psychiatrist were outlined in The right to be safe project report. The department has accepted the MHCC’s overarching recommendation to develop a comprehensive sexual safety strategy to plan, coordinate and monitor action to prevent and respond to breaches of sexual safety in acute mental health inpatient units, and has advised that it welcomes the strengthened focus on sexual safety provided by the project report.

Sexual safety in public mental health services continues to be one of the Chief Psychiatrist’s highest priorities and will be reported on in the Chief Psychiatrist’s annual report. In particular, the Office of the Chief Psychiatrist has undertaken significant work during 2017–18 to update the Chief Psychiatrist’s guideline on promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units, including developing a new sexual safety reporting tool currently being piloted in all public mental health services.

We have been advised of a number of other activities that are underway in the areas of mental health infrastructure, gender sensitivity training, mental health intensive care and reporting and responding to allegations or incidents that serve to address risks and improve patient safety. This work is planned to continue during 2018–19 in the context of the department’s focus on continuous improvement in quality and safety of mental health services, with sexual safety in mental health inpatient units a priority area.

REPORTING ON RECOMMENDATIONS MADE IN PREVIOUS YEARS

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

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

**Response:** The Chief Psychiatrist has advised that his office is developing a guideline that seeks to address issues around the use of electronic devices for communication in Victorian designated mental health services. This guideline seeks to address confusion about the restriction of electronic devices, including telephones, and to outline circumstances where restricting such devices would not be appropriate in inpatient facilities. Additionally, the guideline will promote the rights of consumers to have access to electronic devices, and how communication through such means can facilitate recovery, while taking issues of privacy into consideration. As at 30 June 2018, the draft guideline was in the final stage of consultations.
Recommendation: That the department reviews the program guideline used by health services to charge fees for secure extended care unit (SECU) patients and develop a policy that is consistent with the Mental Health Act 2014 and best practice requirements stipulated in the Chief Psychiatrist’s guideline. The department has advised that this recommendation will be addressed as part of the response to The right to be safe report.

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

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

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

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

Response: Courtyards and outdoor spaces in Victoria’s mental health units were reviewed by the department in 2017–18, and Australia’s national mental health facility guideline (HPU 131 Mental Health) was updated and released on 14 March 2018. The department has also reminded health services about opportunities to review broader issues and consider service/master plans and rectification options, the availability of infrastructure improvement funds and to discuss recommendations with the department to improve services with local solutions. The Victorian Health and Human Services Building Authority is now the lead on Victorian infrastructure improvement funds and to discuss recommendations with the department to improve services with local solutions. The Victorian Health and Human Services Building Authority is now the lead on Victorian health infrastructure services.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.

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

Response: The department has advised that as a result of a coronial recommendation, the Office of the Chief Psychiatrist will develop shared care guidelines between public and private mental health services during 2018–19. This work will be undertaken in collaboration with the Royal Australian and New Zealand College of Psychiatrists. The MHCC will continue to work collaboratively with the department and Chief Psychiatrist to ensure this work also encompasses the recommendations made by the MHCC.
Max said he had received ‘peace of mind’ from hearing about the changes the service had made and that he was relieved something good had come from making the complaint.

Drawn from Max’s complaint on page 31.

OUR ROLE AND APPROACH

Under the Mental Health Act 2014 (the Act), the Mental Health Complaints Commissioner (MHCC) is required to ensure the process for making a complaint is accessible and available to all Victorians. We work with consumers, families and carers to ensure people understand their right to make a complaint about an experience of a public mental health service, and are confident in raising their concerns directly with the service or our office. Our education and engagement initiatives focus on promoting awareness of people’s rights and the mental health principles of the Act, and the safeguarding role and functions of our office.

The Act also requires us to provide mental health services with information and education about their responsibilities and requirements in responding to complaints. We work directly with services to assist them in creating a culture where people are supported to speak up about their experiences and concerns, and where complaints are seen as essential to treatment and care and as opportunities for service improvement. Through our education and engagement work with services, we build their capacity to respond effectively to the concerns people raise, to make service improvements, and to resolve complaints in ways that support people’s recovery and wellbeing.

REVIEW OF OUR EDUCATION AND ENGAGEMENT STRATEGIES

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

Of particular note is our most recent initiative to ensure productive working relationships with clinical mental health services through regular meetings. These meetings allow discussion about trends in complaints data relating to the service and enable sharing of information about service improvements and other issues relating to best practice in complaints handling. Through this process, we have been able to work more closely with service leaders to understand effective approaches to complaints resolution in ongoing matters, as well as to develop more targeted education packages for staff and service leaders.
OVERVIEW OF EDUCATION AND ENGAGEMENT ACTIVITIES

In 2017–18 we delivered a wide range of education and engagement activities for consumers, families, carers, services and other stakeholders including:

- **22** education sessions reaching
- **1295** people, including:
  - presentations at conferences and forums, and to mental health services and other stakeholders, on quality and safety issues identified in complaints
  - training sessions on effective responses to complaints
  - inaugural MHCC learning from complaints forum.

- **23** consumer and carer engagements reaching
- **494** people, including:
  - contributions to consumer and carer events and projects
  - meetings and consultations to promote awareness, input and feedback on our work
  - information sessions to consumer and carer advisory and support groups.

- **11** service visits and meetings to:
  - discuss local and statewide data trends
  - discuss local complaints handling processes and service improvements
  - tailor education sessions to meet service requirements
  - review complaints handling policies and procedures and provide advice.

- **140** people reached through information stands at four key sector events

- **6** articles in mental health journals and health publications, including:
  - the Australian Commission on Safety and Quality in Health Care's Vital Signs 2017
  - the Department of Health and Human Services’ Primary Health News and Health Victoria
  - Tandem eViews.

- **51** other stakeholder meetings and events in a variety of areas to:
  - support and develop our work and ensure effective referrals and working relationships
  - contribute to broader mental health service improvements and reforms.

- **4300** social media followers across Facebook, LinkedIn and Twitter

- **34426** visits to the MHCC website

---

ENGAGING THE SECTOR ON CATALYSTS FOR CULTURAL CHANGE

There are many paths towards cultural change, but what are the catalysts?

In response to our abstract submission, The Mental Health Services (TheMHS) Conference 2017 team included a symposium where mental health commissioners and commissions from across Australia and New Zealand explored this very topic.

Commissioner Lynne Coulson Barr discussed how our team is working with services to improve quality and safety outcomes, and the cultural shift that is required for services to embrace complaints as an integral part of recovery: a window to a person’s lived experience and a catalyst for improving services and the system as a whole.

Commissioner Coulson Barr also joined Senior Education and Engagement Officer Keir Saltmarsh to present on the establishment of the MHCC Advisory Council and the contributions of the lived experience of council members to our work. We walked participants through the process that we undertook to recruit a dedicated, inclusive and diverse group of people with lived experience of the public mental health system, and who seek to contribute to achieving the MHCC’s goals.

We also explored the work involved in ensuring members work together as a collaborative and cohesive team empowered to advise on, and help drive, organisational strategy within the MHCC, and cultural change within the sector. Read more about the MHCC Advisory Council on pages 10–11.

ENGAGING VICTORIANS THROUGH MENTAL HEALTH WEEK

Commissioner Lynne Coulson Barr and other MHCC staff participated in a variety of activities in support of Mental Health Week (8–14 October 2017), an annual event that provides opportunities for engaging and informing the Victorian community about mental health and helping to overcome the stigma associated with mental illness.

These activities included Commissioner Coulson Barr:

- attending the opening of Mental Health Foundation Australia’s Mental Health Week Consumer Art Exhibition
- attending the official Mental Health Week launch event at Federation Square, where our team hosted an information stall and engaged with consumers, families, carers and service staff about our safeguarding role and functions
- taking part in the Department of Health and Human Services’ mental health awareness market day event, where our team distributed information materials and engaged with staff across the health and mental health sectors about our role in safeguarding people’s rights, resolving complaints and improving services
- presenting certificates and the MHCC Award at the Monash Health Mental Health Week Consumer Art Awards
- working with MHCC staff to promote #MentalHealthWeek on our social media sites with a series of posts on artwork created by people with lived experience and the insightful messages they shared.
DEVELOPING A NEW RESOURCE FOR ABORIGINAL PEOPLE IN VICTORIA

In 2017 we developed an information sheet to ensure Aboriginal people in Victoria have access to culturally appropriate and engaging information about their rights under the Act and how to make a complaint. Our new resource will help to raise awareness within the Aboriginal community of their right to speak up about an experience of a public mental health service, and to have their distinct culture and identity recognised and responded to.

In developing the information sheet, we worked with the Victorian Aboriginal Community Controlled Health Organisation to ensure the language and messaging was culturally appropriate, and with Indigenous design team Marcus Lee Design, who created Aboriginal artwork to represent the MHCC’s work in a culturally meaningful way.

Marcus Lee, a descendant of the Karajarri people and Studio Director of Marcus Lee Design, shared with us the story behind the artwork. The rounded shape of the tree symbolises strength, healing and connection, the encircling rings represent trust and safety, and the branches symbolise pathways to recovery for Aboriginal people and communication channels between the MHCC and Aboriginal consumers, families and carers.

This new resource aligns with our continued focus on developing effective strategies for engaging Aboriginal people across Victoria and supports our aim of providing culturally responsive and accessible complaints processes for addressing concerns about Victoria’s public mental health services.

LAUNCHING OUR NEW WEBSITE: A KEY ENabler FOR OUR WORK

In December 2017 we were pleased to launch our new website, which provides access to a broad range of information and resources on our role in safeguarding people’s rights and resolving complaints, working to achieve positive outcomes for individuals, and improving Victorian public mental health services and the system as a whole.

During our consultation process, we gained input and advice from members of the MHCC Advisory Council, who helped to ensure the content reflected the diversity of people’s lived experience as consumers, families, carers and service staff.

Our new website includes:

– information on people’s rights under the Mental Health Act 2014 and the process for making a complaint
– access to a clear and easy-to-navigate online complaint form
– information on our role in identifying, analysing and reviewing quality and safety issues arising from complaints, and working with services to identify key themes and emerging issues across the sector to inform recommendations that lead to service improvements
– a suite of inclusive information materials that includes resources tailored to LGBTI and Aboriginal people and resources in a variety of languages and language formats, including videos in Auslan
– dedicated web pages in 15 languages for Victorians from culturally and linguistically diverse communities.

We invite you to visit our new website at www.mhcc.vic.gov.au and provide feedback to our Education and Engagement team at info@mhcc.vic.gov.au.

EDUCATION AND ENGAGEMENT WITH STAKEHOLDERS

In 2017–18 we delivered a broad range of education and engagement activities for consumers, families, carers, services and other stakeholders on the role of our office, safeguarding rights and effective approaches to resolving complaints. We reached a total of 1,199 people through 60 direct education and engagement activities.

Our activities included 22 training sessions and presentations to a range of audiences within the sector including:

– presentations at national conferences and forums, including at TheMHS Conference, the Australian Rural and Remote Mental Health Symposium, and Victorian conferences hosted by the Victorian Mental Illness Awareness Council (VMIAC), Tandem Carers and Mind Australia
– an education session with third-year psychiatric registrars and a contribution to the University of Melbourne Master of Psychiatry course curriculum
– education and training sessions to service leaders and staff of clinical and mental health community support services on effective approaches to complaints, and to nurse educators as part of the University of Melbourne Centre for Psychiatric Nursing Mental Health Nurse Educator Forum.

When delivering these sessions and presentations, we focused on people’s rights under the Act and how the mental health principles apply to the provision of mental health services and the resolution of complaints. We also focused on quality and safety issues identified in complaints to the MHCC and in local complaints reporting data, and the role of complaints in addressing avoidable harms and promoting service improvements.

In 2017–18 we also focused on education and engagement activities with individual services through meetings with senior staff to discuss themes in complaints data. These meetings have focused on supporting approaches to local resolution of complaints, review of complaints policies and procedures, and the use of information from complaints to inform service improvements.

In 2017–18 we reached 140 people through information stands at four key sector and community events. We also undertook 23 consumer and carer engagements reaching 494 people, where we promoted awareness of our role and helped to ensure our work continues to be informed by the issues identified by consumers, families and carers. These engagement activities included:

– contributions to forums and meetings hosted by VMIAC and Tandem Carers
– consumer-led projects that support recovery and celebrate diversity including the Action on Disability within Ethnic Communities ArtAbility Awards and the Monash Health Mental Health Week Art Awards.
In addition, we undertook 31 contributions to sector consultations, provided formal feedback on seven matters, participated in four key advisory and reference groups and undertook 51 other stakeholder engagement meetings and events. We undertook these activities to support and develop our work and contribute to broader mental health service improvement and reform. These activities included contributions to the rollout of the NDIS and work being undertaken by Safer Care Victoria and the Victorian Agency for Health Information, as well as consultations related to the family violence prevention and child safety reforms.

A total of 39 activities were also undertaken to guide and inform the MHCC Sexual Safety Project.

To ensure effective referrals and working relationships, we attended regular meetings with the Department of Health and Human Services, the Chief Psychiatrist, Safer Care Victoria, Victoria Police, independent mental health advocacy, the Health Complaints Commissioner, the Public Advocate, the Australian Health Practitioner Regulation Agency and other bodies.

To support our work in education and engagement and expand our reach, we continued to promote our activities through our MHCC News e-bulletin, website news stories and regular posts across our Facebook, Twitter and LinkedIn sites. Six articles were also published in mental health journals and health publications, including:

– the Australian Commission on Safety and Quality in Health Care’s Vital Signs 2017 entitled ‘A positive complaints culture: speaking up when something goes wrong can lead to safer care for everyone’ (pages 32–36)

– the Department of Health and Human Services’ Primary Health News and Health Victoria

– Tandem eNews.

[The complaints process] has provided me with a great sense of relief at the prospect that I was not only believed but taken seriously.

Consumer who participated in one of the investigations about sexual safety

Photo posed by model.
OUR LEARNING AND DEVELOPMENT

Key priorities for our professional development activities in 2017–18 included training for all staff in recovery-oriented practice, supported decision making, resilience, and understanding and responding to the needs of trans and gender-diverse Victorians. We also held regular sessions with all staff to share lessons learnt through particular pieces of work, including the MHCC Sexual Safety Project (see the ‘Promoting service and system improvement’ section on pages 41–59). Staff also completed training on our obligations under the Charter of Human Rights and Responsibilities Act 2006, confidentiality and privacy, information security and awareness, and our own health, safety and wellbeing.

All of our permanent resolutions officers are accredited under the National Mediator Accreditation System in association with the Resolution Institute or are working towards accreditation. Our Resolutions and Review team members participate in regular reflective practice sessions to consider how collective and individual practice can be developed and improved.

We also attend a range of sector events to enhance our understanding of best practice, and to learn from others who have specialist knowledge gained through lived experience and/or clinical expertise. These events are listed in detail in the ‘Education and engagement’ section of this report (see pages 60–66).

CONTINUOUS IMPROVEMENT THROUGH EVALUATION AND FEEDBACK

We use the feedback we receive about our processes and approaches to make improvements to how we work. We seek feedback in a range of ways including:

– informally, through our website and social media sites
– formally, through the MHCC feedback survey and internal evaluations of our work and projects
– through responding to concerns and complaints that people raise with us about their experience with our office.

OUR TEAM AND STRUCTURE

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

Consistent with our functions under the Mental Health Act 2014 (the Act), our staff focus on four main areas of work. These are:

– Resolutions and Review
– Specialist Advice and Investigations
– Education and Engagement
– Strategy and Quality

DEVELOPING A LIVED EXPERIENCE FRAMEWORK FOR OUR WORK

We strive to genuinely involve people with lived experience of mental health services in the design, development and delivery of our processes, projects and approaches across all of the four main areas of our work. We do this by:

– engaging with the MHCC Advisory Council to seek their guidance and advice on the approaches we take to our work, their direct contribution to specific projects, and their advice and assistance in facilitating broader input from consumers, families, carers and service providers (read more about the MHCC Advisory Council on pages 10–11)
– conducting targeted consultation for strategic projects and in our education and engagement activities
– ensuring our recruitment processes include consumer and/or family/carer panel members.

In 2017–18 we reviewed all of our activities with a view to assessing the extent to which we currently inform, engage, involve and collaborate with consumers, families, carers, services and other stakeholders, reflecting on where we can improve and identifying the areas where increased engagement will have the greatest impact on the effectiveness of our work. This process will help us to prioritise key areas of our work, clarify what we want to achieve, and develop targeted strategies for specific pieces of work (read more about the mapping of our work in the ‘Education and engagement’ section on pages 60–66).

In 2017–18 we also began work on a lived experience framework to inform and drive the work that is undertaken across our office, and articulate the ways in which the principles of co-design and co-production apply to our work.
Seeking feedback about our complaints processes

MHCC feedback survey

In 2017–18 we continued and refined our formal feedback process, drawing on the results of our 2016–17 pilot feedback survey. Adjustments to our approach included using email-to-text software to send requests to complete the survey, ensuring the survey could be easily completed on a smartphone, and asking for feedback closer to the time of the person’s experience with the MHCC.

As in 2016–17 survey recruitment was influenced by a range of factors, including difficulty in making contact with people to seek their participation. However, the response rate to the survey was within a normal range (14 per cent) and the responses we received contained valuable feedback about what we are doing well and where we could improve.

2017–18 feedback survey results

While we are still analysing the survey results, we note some constructive feedback from participants including:

– feedback about our team’s helpfulness and communication (for example, ‘they were patient and talked through all of the concerns I had and gave simple, clear options to take my complaint further’, with other participants noting that the MHCC staff members they dealt with were ‘very supportive’ and ‘very caring’)

– feedback that most people found it easy to make a complaint to our office (59 per cent) and that our staff had supported them through the process (53 per cent), took the time to listen to them (72 per cent) and clearly explained the information they provided (57 per cent)

– feedback that some people felt that contact with our office had not helped to resolve their concern (for example, people feeling there was a ‘lack of action’)

– concerns about the time taken to resolve their complaint.

The survey results also indicated different levels of satisfaction for particular complaints issues, which we will examine further in the review of our resolutions practice, particularly whether additional or more detailed guidance may be required in responding to certain types of complaints (see ‘Practice review’ on page 71).

We will continue to adjust our processes and approaches to seeking feedback in 2018–19 and explore ways in which we can continue to improve people’s experiences and the outcomes of our complaints processes.

Feedback about our complaints process

In 2017–18 we responded to concerns about our processes, including concerns about the timeliness of our actions, the approach that was taken by our office and the decisions we made.

When a Resolutions and Review team member receives a complaint about our process, wherever possible, they seek to resolve the complaint directly with the person by discussing their concerns and how we can resolve them. Where this is unsuccessful, complaints are escalated to our Principal Legal Officer for further assessment. For each case, we review our approach and consider whether we could have improved the way in which we handled the complaint. Our practice is generally to request a further discussion with the person who has raised the concerns. Where we identify that we should have taken a different or more timely approach, our practice is to apologise and seek to learn from each experience to improve our processes.

For example, feedback has reinforced the importance of communicating clearly with people who contact our office about the proposed next steps, and to carefully consider how we deal with new issues that are raised after an initial written complaint is made.

Where a person is dissatisfied with a decision we have made (for example, a decision to close a complaint) we review the reasons for our decision with regard to the person’s feedback and any additional information that is available. If our decision remains the same, we provide a more detailed explanation of the reasons for the decision and advise the person of their right to make a complaint about our decision to the Victorian Ombudsman.

Improving our processes and approaches

We welcome the feedback that we received from consumers, families, carers and services through the MHCC feedback survey, and through concerns raised directly with our office. In 2017–18 we continued to reflect on the feedback received in earlier years as well as during this year, and undertook the following work to improve our processes and approaches.

Practice review

In 2017–18 we started a project to review the practices of our Resolutions and Review team in light of our experiences to date, feedback received by our office, and high and increasing demand on our services. The project includes:

– reviewing current practice guidance provided to Resolutions and Review team members to streamline practices, ensure consistency in approach, improve timeliness and to assist in the prioritisation of complaints

– ensuring our practice is underpinned by best practice in complaints handling

– developing detailed guidance for staff on key issues identified in complaints (for example, sexual safety)

– reviewing and responding to feedback on our approach to written communication.
Implementation of a new complaints management system

In 2018–19 we will implement a new case management system that is anticipated to reduce administrative burden on the Resolutions and Review team. This system will also have improved reporting capabilities, enabling greater oversight of the progress of complaints and support Resolutions and Review team members in managing their high caseloads.

Timeliness for complaints resolution

In 2017–18 we continued to seek ways to improve our timeliness in resolving complaints. To assist the Resolutions and Review team in managing their significant complaints caseloads, we directed additional resources to this area of our work. We also expanded our internal reporting processes to help identify complaints requiring immediate action and to ensure all complaints are reviewed monthly.

In 2017–18 the MHCC experienced significantly increased demand, with 1,963 complaints received by our office, a 20 per cent increase on the 1,638 received in 2016–17.

Despite the large increase in overall volume, many more complaints were closed in 2017–18 (1,990) than in 2016–17 (1,576). This increase has been largely managed by directing available resources to support resolutions work. Higher numbers of complaints were closed within each time period described below than in 2016–17. However, the increase has had some impact on the average time taken to close complaints. In 2017–18:

- 44 per cent of complaints were closed within seven days compared with 51 per cent in 2016–17
- 69 per cent of complaints were closed within 30 days compared with 73 per cent in 2016–17
- 78 per cent of complaints were closed within 60 days compared with 81 per cent in 2016–17
- 84 per cent were closed within 90 days compared with 86 per cent in 2016–17.

Sixteen per cent of all complaints took more than 90 days to close (a slightly higher proportion than 14 per cent in 2016–17). This reflects a consistent proportion of complaints that are particularly complex and require detailed assessment and review before they can be resolved and closed.

Flexibility in contact

In 2017–18 we implemented an email-to-text system for our Resolutions and Review work, which we also used in conducting the MHCC feedback survey. This system offers an additional method of contact, allowing us to provide brief updates to people when we are unable to reach them through other channels. In doing so, we aim to ensure people are kept informed about the progress of their complaint as this information comes to hand.
Appendix 1: EDUCATION AND ENGAGEMENT ACTIVITIES

01 PRESENTATIONS
Conferences and forums
Australian and New Zealand Mental Health Association 9th Australian Rural and Remote Mental Health Symposium
Ballarat Mental Health Service Forum
MHCC Inaugural Learning from Complaints Forum on Complaints and Avoidable Harms – ensuring sexual safety in acute mental health inpatient units
Mind Community Conference 2017
National Symposium on the Optional Protocol to the Convention Against Torture (OPCAT) – panel convener
TheMHS Conference 2017 – Mental Health Commissions’ symposium on catalysts for cultural change
TheMHS Conference 2017 – presentation on the MHCC and the MHCC Advisory Council
Victorian Aboriginal Community Controlled Health Organisation Social and Emotional Well Being Workforce Conference
Victorian Ombudsman Masterclass – guidance for the Victorian public sector on dealing with challenging behaviour

Presentations to mental health services/other stakeholders
Health Services Liaison Association – presentation on MHCC complaints data and themes
NDIS Quality and Safeguards information session for new and potential service providers, hosted by the Department of Health and Human Services (DHHS)
Office of the Public Advocate (OPA) staff and Community Visitors Program – presentation on the MHCC’s Sexual Safety Project report. The right to be safe
South Korean mental health services delegation – presentation at DHHS on the MHCC’s role
Victorian Board of the Medical Board of Australia – presentation on MHCC complaints data and themes
Victorian Mental Health Interprofessional Leadership Network – presentation on the MHCC’s role and effective approaches to complaints

02 TRAINING SESSIONS
Albury Wodonga Health
Eastern Health
North East Victoria Innovative Learning (NEVIL) Cluster
The University of Melbourne Centre for Psychiatric Nursing Mental Health Nurse Educator Forum
The University of Melbourne Master of Psychiatry course Special Topics in Psychiatry

03 EDUCATION ACTIVITIES
Information stands
DHHS Mental Health Awareness Market Day event
Mental Health Foundation Australia Mental Health Week launch event
Mind Community Conference 2017
Victorian Mental Illness Awareness Council (VMAC) Conference 2017

04 SERVICE VISITS AND MEETINGS
Albury Wodonga Health
Ballarat Health
Eastern Health
Forensicare, Thomas Ebling Hospital
Mildura Base Hospital (via video link)
Mind Australia
Monash Health

05 CONSUMER AND CARER ENGAGEMENTS
Action on Disability within Ethnic Communities (ADEC) Antability launch and awards
Carer Support Group, Harvester Clinic, North Western Mental Health
Mental Health Foundation Australia Mental Health Week Art Awards
Mental Health Tribunal Consumer and Carer Forum and liaison meetings
Midsumma Pride March
Monash Health Mental Health Week Art Awards
NADCC Week March
National Mental Health Consumer and Carer Forum
Tandem Carers Conference and Awards
Tandem Carers meetings and consultations
VMAIC Conference 2017
VMAIC meetings and consultations
Voices of Consumer and Carer Advisory Link, Saltwater Clinic, Mercy Health

06 CONTRIBUTIONS TO CONSULTATIONS AND PROJECTS
Contribution to sector consultations and projects
Australian Human Rights Commission project on violence against people with disability in institutional settings
Australian Mental Health Outcomes and Classification Network Your Experience of Service (YES) survey
Consultation on models for a mental health commission in the ACT
Crime Statistics Agency Victoria draft family violence data framework
DHHS child wellbeing and safety information-sharing reforms
DHHS and Department of Premier and Cabinet (DPC) proposals for the registration and accreditation scheme for the disability workforce
DHHS and DPC transition planning for the NDIS – complaints, quality and safeguarding functions
DHHS consultation on proposed legislative amendments to facilitate information sharing about family violence risk
DHHS consultation on proposed legislative amendments to facilitate information sharing between DHHS and the MHCC
DHHS consultation on treatment options for people with complex needs including mental illness and drug addiction
DHHS review of non-custodial supervision orders
DPC Victorian Data Sharing Regulations 2018 consultation
Forensicare strategic planning
Health Complaints Commissioner complaint handling standards and practice protocol
Human Rights Law Centre and Commissioner for Gender and Sexuality gay conversion therapy research project
Mediator Standards Board statutory mediation and conciliation standards consultation
Mental Health Complaints Commissioner and Carer Engagement Project workshop
Office of the Chief Psychiatrist (OCP) Advance Statements and Nominated Persons Project
OCP discharge planning guideline
OCP surveillance and privacy in Victorian designated mental health services consultation
Office of the Commissioner for Privacy and Data Collection
Victorian Protective Data Security Standards
Opa review of Community Visitors Program and Independent Third Person Program

07 SUBMISSIONS AND FORMAL FEEDBACK
DHHS proposals for alternative arrangements for managing violent and aggressive behaviour
NDIS Quality and Safeguards Commission market oversight – response to the consultation paper
NDIS Quality and Safeguards draft rules legislation
OCP draft mental health intensive care guidelines
Royal Australian and New Zealand College of Psychiatrists position statement on supported decision making
Statutory Duty of Candour Targeting zero recommendations – response to the consultation paper
Victorian Ombudsman draft good practice guide to dealing with challenging behaviour

08 PARTICIPATION IN ADVISORY AND REFERENCE GROUPS
Culturally and Linguistically Diverse Communities Grants Advisory Group – joint VMAIC and Tandem Carers project
DHHS Progress Measures Working Group
OCP Human Rights Project Advisory Group
Safer Care Victoria Project Group on Targeting zero recommendations – information-sharing provisions

RMT consultation on the impacts of the transition to the NDIS for people with disabilities
The University of Melbourne Master of Psychiatry online teaching materials
Victorian Auditor-General’s Office (VAGO) consultation on future performance audit topics
Victorian Agency for Health Information draft corporate plan 2017-18
VAGO audit of access to mental health services
Victorian Equal Opportunity and Human Rights Commission (VEOHRC) review of Dispute Resolution Service
Victorian Ombudsman OPCAT-style investigation of the Dame Phyllis Frost Centre
Women’s Mental Health Network: Victoria strategic planning
Consultations for the MHCC Sexual Safety Project
More than 100 people and organisations consulted – for details, see Appendix 1 of The right to be safe report
09 OTHER STAKEHOLDER MEETINGS AND EVENTS
Australian and NZ Mental Health Commissioners meetings and consultations
Australian and NZ Health Complaints Commissioners meetings and consultations
Commissioner for Senior Victorians liaison and consultation meetings
DHHS liaison and consultation meetings
Disability Services Commissioner liaison and consultation meetings
Health Complaints Commissioner liaison and consultation meetings
Independent mental health advocacy (IMHA) liaison and consultation meetings
LGBTI Mental Health Network meeting
Mental Health Tribunal liaison and consultation meetings
OCP Quality and Safety forums
OCP liaison and consultation meetings
OPA liaison and consultation meetings
Orygen – The National Centre of Excellence in Youth Mental Health meeting
Safer Care Victoria liaison and consultation meetings
Victorian Agency for Health Information liaison and consultation meetings
Victorian Commissioner for Gender and Sexuality liaison and consultation meetings
VEOHRC liaison and consultation meetings
VEOHRC Victorian Commissioners meetings on human rights issues
Victorian Honour Roll of Women Ambassadors workshops on violence prevention and gender equality strategies
Victorian Mental Health Interprofessional Leadership Network meeting
Victorian Ombudsman liaison and consultation meetings and events

10 PUBLISHED ARTICLES
Health Victoria on the launch of the MHCC’s new website
Health Victoria on the MHCC’s inaugural forum on ensuring sexual safety in acute mental health inpatient environments
Primary Health News on the launch of the MHCC’s new website
Primary Health News on the MHCC’s inaugural forum on ensuring sexual safety in acute mental health inpatient environments
Tandem eNews on the MHCC’s inaugural forum on ensuring sexual safety in acute mental health inpatient environments
The Australian Commission on Safety and Quality in Health Care’s Vital Signs 2017 entitled ‘A positive complaints culture: speaking up when something goes wrong can lead to safer care for everyone’ (pages 32–36)

FINANCIAL STATEMENT FOR THE YEAR ENDED 30 JUNE 2018
The Department of Health and Human Services provides financial services to the Mental Health Complaints Commissioner (MHCC).
The financial operations of the MHCC are consolidated into those of the department and are audited as part of the department’s 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 2017–18 according to the department’s accounts is provided below.
This expenditure includes additional fixed term funding received from the department in 2017–18 to support the MHCC’s operations.

OPERATING STATEMENT FOR THE YEAR ENDED 30 JUNE 2018

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and on-costs</td>
<td>$2,538,442</td>
</tr>
<tr>
<td>Contractors/external services</td>
<td>$222,847</td>
</tr>
<tr>
<td>Supplies and consumables</td>
<td>$489,646</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td><strong>$3,250,935</strong></td>
</tr>
</tbody>
</table>
Appendix 3: COMPLIANCE AND ACCOUNTABILITY

PRIVACY AND DATA PROTECTION ACT 2014 AND HEALTH RECORDS ACT 2001
The Mental Health Complaints Commissioner (MHCC) is subject to the Privacy and Data Protection Act 2014 in relation to the collection and handling of ‘personal information’ about individuals. ‘Personal information’ is recorded information that can identify a living person.

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

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

FREEDOM OF INFORMATION ACT 1982
In 2017-18 the MHCC made three decisions relating to Freedom of Information (FOI) applications.

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

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

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

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

PROTECTED DISCLOSURE ACT 2012
Disclosures of improper conduct by the MHCC or its officers can be made verbally or in writing to:
Independent Broad-based Anti-corruption Commission
GPO Box 24234
Melbourne VIC 3000
Phone: 1300 735 135
Fax: 03 8635 6444
Email: submit@ibac.vic.gov.au