Spotlight on safeguarding rights and upholding the mental health principles
2014–15
Victoria’s new mental health legislation, enacted on 1 July 2014, aims to protect the rights and dignity of people experiencing mental illness, and place them at the centre of their treatment and care.
It introduces a set of mental health principles and a number of new initiatives and protections to promote and support recovery and facilitate strong communication between mental health professionals and consumers, families and carers. These include:

- a supported decision-making model to enable people to make or participate in decisions about their assessment, treatment and recovery and have their views and preferences respected and considered
- a commitment to voluntary treatment wherever possible, and safeguards to minimise the duration of compulsory treatment
- a comprehensive suite of safeguards, oversights and service improvement mechanisms to ensure rights are protected, the mental health principles are upheld, and compulsory treatment is minimised.

The Mental Health Complaints Commissioner (MHCC) is a key component of these mechanisms and works to:

- safeguard the rights and dignity of individual consumers, families and carers
- resolve complaints in ways that support recovery and improve services
- help services to develop effective complaint resolution processes
- drive improvements in the mental health system.

This document provides examples of our 2014–15 work with consumers, families, carers and services to safeguard rights and use the rights, principles and provisions of the Act to resolve complaints and improve outcomes.

More information about complaint data is in Spotlight on Mental Health Complaints 2014–15 and in our Annual Report. Both are available on our website.
The Act introduces a supported decision-making framework to enable people to make or participate in decisions about their assessment, treatment and recovery. This new framework requires different conversations between consumers, families, carers and services to ensure a person’s views and preferences are considered.

In our approach to complaint resolution, we work to build the capacity of all parties to have these conversations and use the supported decision making mechanisms available in the Act, such as advance statements, nominated persons and second psychiatric opinions, to minimise and resolve complaints.

To support decision making, the Act gives people the right to make an advance statement about their treatment preferences, to nominate a support person to receive and provide information about treatment and care while a compulsory patient, and to have access to a second psychiatric opinion.

In 2014–15, a number of complaints to MHCC related to consumer concerns about how a service considered and responded to these rights when providing care and treatment. Where the person was very unwell or had difficulty expressing their views and preferences, the MHCC asked services to explain how they had considered the person’s views and preferences.

We also promoted the use of these mechanisms to help resolve complaints and prevent the concerns raised from reoccurring. Many services proactively discussed these options with people when working to resolve a complaint, and we have seen how a person’s confidence and trust have been restored when services take steps to understand their experience and engage with their views and preferences.
‘Max’ made a complaint to the MHCC saying he did not feel his treating team was listening to his concerns about the side effects of his medication. On a compulsory treatment order, Max was receiving his medication orally each morning. The service had changed his medication from injectable medication to oral medication at his request, but Max was now feeling drowsy every day because of the timing of the medication. He felt the medication was affecting his ability to get back to work and was also concerned about a recent change in his diagnosis. He was worried he would be put back on injectable medication if he complained to the service, because his record indicated ‘non-compliance’ when being treated by another service. Max said he had tried to have this information corrected, but the service had told him they couldn’t change the records.

MHCC worked through the complaint with Max and the service to explore how Max could be supported to be involved in discussions and decisions about his treatment, and have his views and preferences considered. The service recognised that they should have been proactive in seeking Max’s views about his treatment and how best to support his recovery goal of returning to work. They agreed to meet with him to review the timing of his medication and his overall treatment and recovery plan, and to arrange a second psychiatric opinion. They also agreed to make a notation on Max’s file outlining his concerns about the information recorded by the previous service and to include Max’s account of events in any future reports to the Mental Health Tribunal. As an outcome of this complaint, Max’s medication was adjusted and he felt more confident to raise his concerns directly with the service and supported in his recovery.

‘Wendy’ made a complaint to MHCC saying that when she was a compulsory patient in a service, she was prevented from speaking to police after allegedly being assaulted by a co-patient. She said that although she was eventually able to speak with the police, she had been distressed by the initial response from staff who had determined she wasn’t well enough to speak with the police.

In working through the complaint with Wendy and the service, the service agreed to develop a new policy to help ensure appropriate responses were in place to protect patient safety and enable consumers to exercise their right to communicate with others outside the service. The service also made an unreserved apology to Wendy and advised that their staff would undertake new training in preventing and responding to incidents.
A key objective and principle of the Act is for people to receive assessment and treatment in the least restrictive way possible, with the least possible restrictions on human rights and dignity. Many consumer complaints to the MHCC include concerns about compulsory treatment and whether their treatment is the least restrictive.

Whenever a person raised concerns about their compulsory status, we talked to them about the Mental Health Tribunal’s role and ensured they understood their rights in relation to the Tribunal. We also asked the service to confirm that they were providing information about the Tribunal’s processes and support to enable the person to exercise their right to seek a hearing for a decision about their order.

The right to the least restrictive treatment is also a key consideration in complaints about the use of seclusion and restraint, medication and particular treatment settings such as high dependency units and secure extended care units (SECU’s). In dealing with these complaints, we reviewed and assessed the extent to which the service considered less restrictive options and any steps that could be taken to ensure treatment is least restrictive. We also assess whether the specific requirements and protections under the Act have been met, and where appropriate, consult with the Chief Psychiatrist who has the statutory function of monitoring the use of these restrictive interventions.

We give close attention to enquiries and complaints that raise issues of risk, safety and alleged harm. In cases involving risk, safety or alleged harm, we assess the adequacy of the service’s immediate and longer-term response, including any investigation and reporting to police. We also assess the steps the service has taken to respond to the individual’s needs, to address risk issues and to prevent a reoccurrence. The action we take is informed by this assessment and consideration of the roles of other bodies such as Australian Health Practitioner Regulation Agency (AHPRA), the Coroner, Victoria Police and the Chief Psychiatrist.

We have begun discussions with the Department of Health and Human Services and the Chief Psychiatrist on options for ensuring greater consistency in the way services report, investigate and review incidents and use open disclosure in relation to adverse events.

We note services, particularly those with older inpatient units, face a number of challenges because of the physical layout of units, with the location of staff stations, the design of high dependency units, and limited physical amenities in courtyards and common areas of particular concern. Variable gender ratios and high demand for inpatient beds can also make providing gender specific areas difficult.

We will use the experience and knowledge we have gained in our first year to inform our approach to addressing specific complaint issues and any future recommendations we may make for addressing the broader quality and safety issues identified in complaints.
EXAMPLE COMPLAINT

In working with the MHCC to resolve a complaint about the way a service had handled arrangements for a young child to visit his mother in an inpatient unit, the service offered to work with the consumer and her partner to include an advance statement on requested arrangements for any future visits, as well as placing an alert on the consumer’s file. The option of the consumer officially nominating her partner as her ‘nominated person’ under the Act was also discussed as another way of facilitating optimal communication and consideration of his wishes and preferences for future visits. The service also identified the need to develop more detailed policy guidance for staff for arranging such visits to ensure consistency with the principles of the Act, including promoting the best possible therapeutic outcome for the consumer and the best interests of the child.

EXAMPLE COMPLAINT

The mother of a son who was recently diagnosed with schizophrenia rang because she wanted to provide extra information to a service. She felt that her son was presenting well, but was not really coping. As his carer, she wanted the service to know of her concern. She had left messages for her son’s case manager, but had not received a reply. She did not want to talk to her son about making a complaint as he was ambivalent about receiving treatment.

We discussed the requirement for services to involve carers wherever possible and to have a process for hearing concerns and receiving information from carers. We helped her raise her concerns directly with the service and obtained a commitment from the service to address the lack of response from the case manager. The mother was able to speak with the treating team to outline her concerns so the team could consider them in their discussions with her son about his treatment options.

“I hope that the Mental Health Complaints Commissioner will improve people’s experiences of making complaints.”

– Consumer
We received a number of complaints from consumers about whether their individual needs, including those of culture, language, communication, age, disability, religion, gender and sexuality were being met. We also received complaints from consumers and carers expressing concern that consumers’ holistic needs, including physical health and alcohol and drug related treatment needs, had not been met while receiving mental health services.

These complaints usually occurred when people were compulsory inpatients and unable to access their usual community supports or services, or where they needed additional support to access appropriate services. We were often able to resolve these complaints in the early stages by supporting the person to communicate directly with the service about their needs. In some instances, we engaged services on the need to develop coordinated treatment and care plans with other services, such as disability services, to respond to the specific needs identified in complaints.

The Act also requires services to recognise and promote the best interests of children and young people, and recognise and promote their wellbeing, needs and safety. This requires services to adopt a holistic and individualised approach to care and treatment planning. Through some complaints, services have agreed to adopt tailored approaches to visits by children during a parent’s inpatient admission and reconsider their approaches to discharge planning for consumers with parental responsibilities.

Our experience dealing with complaints about services to young people and our visits to all Victorian public youth mental health services, including Youth Prevention and Recovery Centres (YPARCs), has reinforced the importance of such tailored and individualised responses.

We have provided advice and guidance to carers about how to navigate a complaint process, provided advice to services about the rights of carers under the Act, and facilitated complaints back to the service for local resolution.
Under the Act, compulsory patients must be given a statement of rights when they are placed on an assessment, treatment or a temporary treatment order. The service must explain these rights in a way that helps the person understand their rights and how they are going to be assessed or treated. The Act also requires the service to provide copies of assessment or treatment orders to the person.

Some complaints have raised concerns about the timing of the provision of the statements of rights and copies of orders or reports relating to the Mental Health Tribunal. In most cases, the service has agreed to explain the rights again directly to the person, and provide another copy of the statement. We have also encouraged services to see this practice as part of their ongoing conversation with the person and ensure it continues throughout the period of compulsory treatment.

The recognition of the role of carers and acknowledgment that carers should be involved in decisions about assessment, treatment and recovery wherever possible are significant changes in the Act, and are important for promoting supported decision making.

In dealing with enquiries and complaints from carers, we have identified the need for services to develop new approaches for understanding and responding to the concerns of carers, and implementing processes to ensure carers of compulsory patients are notified and consulted as required by the Act. As an outcome of complaints made to the MHCC, two services formally reviewed their policies and practices to ensure that carers were appropriately notified and involved in treatment and care decisions.

Most of the complaints we receive from carers are made with the agreement and support of the consumer. There are times when we have been unable to deal directly with a complaint made by a carer because the Act requires us to obtain the consumer’s consent or assess that there are special circumstances and that accepting the complaint will not be detrimental to the consumer’s wellbeing. The Act also requires us to notify the consumer when we accept and close a complaint.

Where we are unable to formally deal with a complaint, the Act allows us to support the person to resolve their complaint directly with the service. We have provided advice and guidance to carers about how to navigate a complaint process, provided advice to services about the rights of carers under the Act, and facilitated complaints back to the service for local resolution.
Right to communicate privately with people outside a service

The Act sets out the right for people to communicate with people outside a service, and requires staff to ensure reasonable steps are taken to support such communication.

The MHCC received a number of enquiries and complaints about the lack of access to or confiscation of mobile phones, tablets or laptops from consumers during inpatient admissions. We identified variable practices across services, and questioned whether all practices were consistent with the rights and requirements of the Act, including the principles about least restrictive treatment and recovery-oriented practice.

Following discussions with the Department of Health and Human Services and the Chief Psychiatrist, we have formally referred the need for policy and practice guidance on access to mobile phones and other communication devices for consumers during inpatient admissions to the department for consideration.

We have also identified a small number of complaints where a person has not been supported to contact, or has been prevented from communicating with, a person or agency (for example, the police) despite there being no direction to restrict communication by the authorised psychiatrist.

We have begun to talk with services about their responsibilities in relation to this right, and have made recommendations to a number of services to review their policies and procedures to ensure they comply with the Act.

‘The MHCC treated me with dignity and respect and, most importantly, they displayed empathy towards my circumstances which validated my experience and gave me hope.’

– Consumer

Please note: Names and details in all example complaints have been changed or omitted to protect the identity of the people and services involved.
People receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred. – Mental Health Act 2014 s11(1)(a)

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. – Mental Health Act 2014 s11(1)(b)

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. – Mental Health Act 2014 s11(1)(c)

People receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk. – Mental Health Act 2014 s11(1)(d)

People receiving mental health services should have their rights, dignity and autonomy respected and promoted. – Mental Health Act 2014 s11(1)(e)

People receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to. – Mental Health Act 2014 s11(1)(f)

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. – Mental Health Act 2014 s11(1)(g)

Aboriginal people receiving mental health services should have their distinct culture and identity recognised and responded to. – Mental Health Act 2014 s11(1)(h)

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. – Mental Health Act 2014 s11(1)(i)

Children, young people and other dependents of people receiving mental health services should have their needs, wellbeing and safety recognised and protected. – Mental Health Act 2014 s11(1)(j)

Carers (including children) for people receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible. – Mental Health Act 2014 s11(1)(k)

Carers (including children) for people receiving mental health services should have their role recognised, respected and supported. – Mental Health Act 2014 s11(1)(l)
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