

## Mental Health Complaints Commissioner Annual Report Summary 2020

The Mental Health Complaints Commissioner (MHCC) is an independent specialist body established under the *Mental Health Act 2014* to safeguard people's rights, resolve complaints about Victoria's public mental health services and recommend service and system improvements. To find out more, please see our website: [mhcc.vic.gov.au](http://mhcc.vic.gov.au).



### Driven by lived experience

The MHCC has a clear commitment to the experiences and voices of people with a lived experience. — MHCC Advisory Council member

The MHCC is committed to being driven by the lived experience of consumers, carers and families in everything we do.

Our staff and Advisory Council have completed a *Driven by lived experience framework and strategy*, which will guide our work into the future. It includes:

- A new Driven by lived experience principle
- a Driven by lived experience tree that shows the experiences we'd like people to have when they engage with the MHCC
- statements describing the actions we will take to achieve this
- a three-year strategy to further strengthen the ways we are driven by lived experience.



### Education and engagement activities

In 2019–20, we completed:

- 27 contributions to sector consultations and projects
- 19 sector events
- 6 advisory and reference group memberships
- 80 stakeholder meetings and events
- 34 direct education and engagement activities.

### Royal Commission into Victoria's Mental Health System

Our contributions to the Royal Commission highlight the critical issues of rights, safety and quality identified in complaints to the MHCC and how complaints can drive improvements to service and system reform. In 2019–20, we:

- made a formal submission to the Royal Commission
- provided a detailed witness statement from the Commissioner
- shared copies of local complaints reports, a summary of responses to recommendations made in our sexual safety report *The Right to be Safe*, and an analysis of sexual safety complaints received in 2017–18 and 2018–19.

### Risk, safeguarding and human rights issues

We review all complaints against the requirements of the *Mental Health Act 2014* and *Victorian Charter of Human Rights and Responsibilities 2006*. In 2019–20, 36 complaints that raised risk, safeguarding and human rights issues were subject to actions including investigations, conciliations, legal undertakings and detailed assessments which resulted in service improvement recommendations. These complaints involved issues such as alleged breaches of the Act, questions about the lawfulness of service actions, risks of abuse or neglect of consumers, and significant harms experienced by consumers.

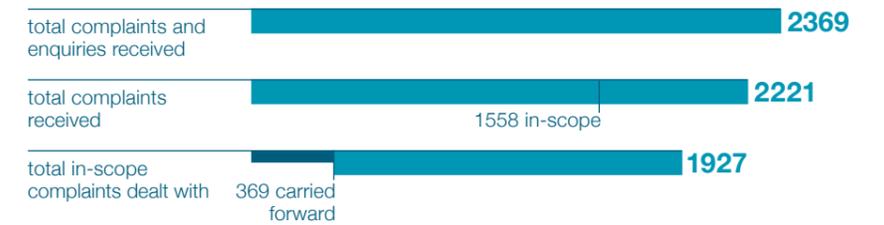
## Overview of complaints 2019–20

I was struck by how kind you were to me...we both feel very confident that the complaint is in good hands. — Consumer

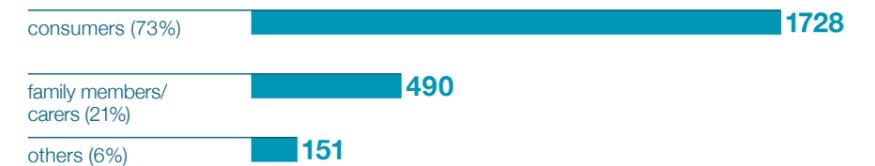
Speaking up can create change for an individual and also improve the mental health system for others.

### How many enquiries and complaints did people make?

In 2019–20, we dealt with more enquiries and complaints than in any other year.



### Who made enquiries and complaints?



### What type of services were complaints about?

Of the 1,558 in-scope complaints made to the MHCC in 2019-20, 1,507 (97%) were about designated mental health services (DHMS), with 81% of these adult mental health services.

### What did people make complaints about?

Most complaints to the MHCC involve more than one issue.

**2774**

**treatment:** mostly about disagreement with treatment orders and inadequate treatment options or planning

**762**

**communication:** mostly about receiving inadequate, incomplete or misleading information

**654**

**staff conduct and behaviour:** mostly about staff manner, such as rudeness, or a lack of respect or empathy

**539**

**medication:** mostly about dissatisfaction with medication, including side-effects

# What happens because of complaints?

Great advice and support in resolving complaints.  
— Consumer

## Complaints closed in 2019–20



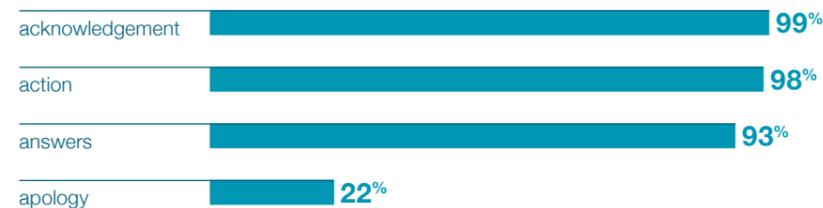
Of the MHCC's closed in-scope complaints:

- 819 were dealt with through our resolution processes
- 188 were facilitated to the service for resolution
- 566 were assessed as 'resolution not applicable/possible', for reasons such as being unable to contact the person who made the complaint.

When concerns are more appropriately dealt with by another body, people receive advice, support and referrals from the MHCC.

## What happened when people made a complaint?

Of the 819 complaints closed by the MHCC, 82% had positive outcomes and actions. Outcomes in these complaints are grouped below by the four As of complaints resolution.



## How many improvements were made?

**276** improvement actions were taken including:

**121** recommendations to mental health services

**148** improvements made by services

**4** formal undertakings from services to take actions in response to acknowledged breaches of the Act and other safeguarding issues

**3** systemic recommendations<sup>2</sup> about:

- suicide attempts in inpatient units
- prolonged use of mechanical restraint in emergency departments
- issues that arise when emergency departments are not part of a DMHS.

<sup>1</sup> Most complaints deemed out of scope were not about a Victorian public mental health service.

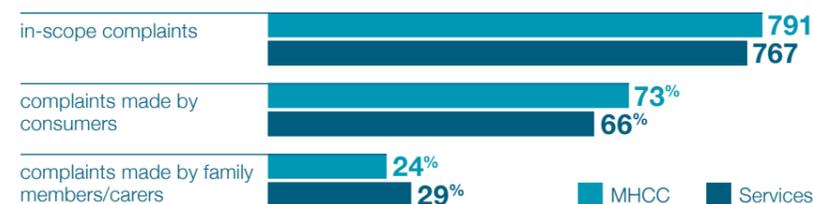
<sup>2</sup> Systemic recommendations were made to the Secretary of the Victorian Department of Health and Human Services (DHHS), the Chief Psychiatrist and Safer Care Victoria.

# Local complaints reporting

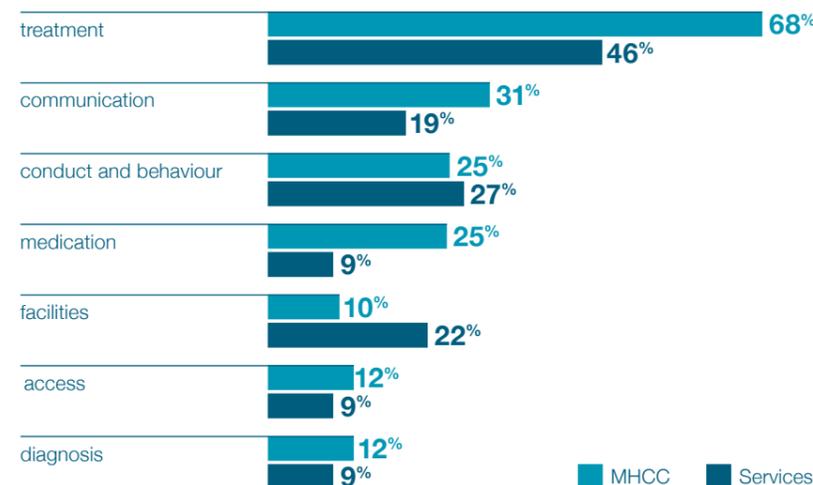
The MHCC has encouraged us to engage with complaints and feedback more than we might otherwise do through our internal complaints system. — Service provider

All DMHS provide the MHCC with data about complaints made to them. We compare this data to ours to inform our work and help services identify where people's experiences can be improved. We delayed requests for January–June 2020 data to minimise demands on mental health services during COVID-19, so figures below show comparisons for July–December 2019 only.

## Comparison of complaints to MHCC and services (July–December 2019)



## Frequency with which issues were raised in complaints to MHCC and services (July–December 2019)



The percentage of complaints to services where people raised treatment, communication and medication issues was much lower than complaints to the MHCC. People have the right to be informed and make decisions about their treatment and should be supported to raise these concerns with their treating team.

In 2019, we distributed reports to each DMHS comparing data from complaints to the MHCC and services from 2015–16 to 2017–18, to assist them in identifying quality and safety issues and making service improvements. We also shared these reports with the Royal Commission, DHHS, Safer Care Victoria and VAHI, and published a report about state-wide trends.

# Example complaint: Sam and COVID-19

## What Sam told us

Sam called us after being admitted to an inpatient unit during the early stages of the COVID-19 pandemic. He was feeling very stressed by the tense atmosphere in the unit as well as its restrictions, such as not being able to get food of his choice, or smoke. He felt that his treating team were not considering his previous diagnoses, or the best ways to support him.

## Sam's rights

Victoria's *Mental Health Act 2014* and its principles protect the rights of people like Sam, who are receiving mental health treatment from a public mental health service. Services must continue to consider the mental health principles when implementing COVID-19 Public Health Directives and restrictions. Sam has the right to receive treatment in the least restrictive way possible, in a way that responds to his individual needs and supports his recovery, and to make decisions about his treatment.

## What we did

We talked to the Nurse Unit Manager about what Sam wanted, including for the service to find ways to reduce the negative impacts of the COVID-19 restrictions on consumers. The Nurse Unit Manager spoke with Sam, considered his concerns and agreed to increase:

- the availability and choice of food for consumers
- access to leave for smoking and supports for quitting, and
- staff engagement with consumers, despite the difficulties of COVID-19.

The Nurse Unit Manager acknowledged that staff had not been responsive to Sam's needs and preferences for treatment, and the stress being experienced by consumers in the unit. She also talked to Sam about the value of having an Advance Statement, which could help to guide his treating team and other staff if he was admitted again in the future. The Clinical Director confirmed that all of the improvement actions would be undertaken.

## Outcomes

Sam told us that his concerns had been heard and addressed by the service and the MHCC. He felt pleased that in helping himself and other consumers, he had also contributed to the broader COVID-19 mental health response. This is because, from the outset of the COVID-19 pandemic, the MHCC has worked with DHHS and the Office of the Chief Psychiatrist to share information from complaints ensuring guidance given to services during the pandemic is directly informed by people's views and experiences.

# Everyone's experience matters

Please see the MHCC's full annual report for more information about our work at: [www.mhcc.vic.gov.au/resources/publications](http://www.mhcc.vic.gov.au/resources/publications).

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

Level 26, 570 Bourke Street, Melbourne VIC 3000, Australia  
Phone: 1800 246 054  
Fax: (03) 9949 1506  
Complaints: [help@mhcc.vic.gov.au](mailto:help@mhcc.vic.gov.au)  
Feedback: [feedbackaboutus@mhcc.vic.gov.au](mailto:feedbackaboutus@mhcc.vic.gov.au)  
Other: [info@mhcc.vic.gov.au](mailto:info@mhcc.vic.gov.au)  
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