

The Royal Commission into Victoria's Mental Health System

**Submission from the Mental Health Complaints
Commissioner**

July 2019

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A note on language

We recognise that a broad range of views and preferences exist concerning appropriate language to describe people who have lived experience of mental health issues. Throughout this submission, we use words and terms that are consistent with those that appear in the *Mental Health Act 2014* (the Act). Wherever possible, we use person-centred, recovery-oriented, inclusive language.

Common words and their meanings

- *Consumer* — a person who has accessed mental health services
- *Services / public mental health service providers* — designated mental health services and publicly-funded mental health community support services
- *Designated mental health services* — health services 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.

Abbreviations used in submission	
MHCC	Mental Health Complaints Commissioner
Act	<i>Mental Health Act 2014 (Vic)</i>
Charter	<i>Victorian Charter of Human Rights and Responsibilities Act 2006 (Vic)</i>
UN	United Nations
DHHS	Department of Health and Human Services
OPCAT	Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
Secretary	Secretary of the Department of Health and Human Services
Minister	Minister for Mental Health
OCP	Office of the Chief Psychiatrist
VAHI	Victorian Agency for Health Information
'Right to be Safe' report	Report produced by the MHCC titled: <i>The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report</i> March 2018
'Targeting Zero' report	Report by commissioned by DHHS titled: <i>Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care</i> 2016
CATT	Crisis Assessment and Treatment Team
LGBTI	This term is commonly used term used by government to include people who are lesbian, gay, bisexual, transgender, intersex, queer or questioning, and asexual or allied
MHT	Mental Health Tribunal
ECT	Electroconvulsive treatment
ICA	Intensive Care Area (also commonly referred to as High Dependency Unit or HDU)

Mental Health Complaints Commissioner's Submission

Introduction

The Mental Health Complaints Commissioner (MHCC) is pleased to provide this submission to the Royal Commission into Victoria's Mental Health System (the Royal Commission). This submission responds to the questions posed by the Royal Commission by drawing on the key insights and themes identified in the MHCC's performance of its statutory functions since its establishment in July 2014 under the *Mental Health Act 2014* (the Act).

As Australia's only independent mental health complaints body, the MHCC has developed a deep understanding of people's experiences in the Victorian mental health system from the concerns raised by consumers, families and carers and the responses from services to these issues. The MHCC holds a wealth of data (over 16,000 complaints¹) that provide vital insights into people's experiences with the Victorian mental health system and highlight areas that require attention to uphold rights, embed the principles of the Act and improve services. Through carrying out our education and engagement functions with consumers, families, carers and services, the MHCC is also able to identify broader issues of concern and factors impacting on people's experience of mental health services. The MHCC's work with services also provides a window into the challenging environments and circumstances in which staff work. Common pressures staff face include managing high demand for services, resource constraints, outdated infrastructure and complicated and complex models of care which make it difficult for committed staff to provide responsive and safe care within the current system.

The MHCC's observations of the first five years of the operation of the Act are that the intended shift to person-centred, rights-based and recovery-oriented practices, along with the expected cultural changes in public mental health services, has not yet been realised. Complaints to the MHCC indicate significant issues and gaps in the extent to which services' approaches reflect the principles of respecting people's autonomy and dignity, supported-decision making, the least restrictive treatment and the meaningful involvement of families, carers and nominated persons. It is important to acknowledge that services predominantly share the concerns that are identified in complaints to the MHCC and work with our processes to address the individual concerns and to improve their practices. Of greatest concern for the MHCC are the significant breaches of people's rights and avoidable harms that have been identified in complaints about public mental health services and emergency departments. This submission therefore focuses on the actions required to safeguard people's rights and prevent the harmful and traumatic experiences that can be associated with the operation of the current mental health service system.

¹ These includes complaints made directly to the MHCC and local complaints reported by services for five years from 2014/15 to 2018/19. Note the numbers of local complaints reported by services in 2018/19 were subject to completion and validation at the time of this submission.

Part A of this submission provides background information on the MHCC's role, functions and approach and overarching considerations for the Royal Commission's inquiry into Victoria's mental health system. The information outlined in Part A provides the context and basis to the MHCC's responses to specific questions posed by the Royal Commission in Part B of the submission. The information and suggestions provided in this submission are drawn primarily from themes identified from complaints and the performance of the MHCC's functions.

PART A:

Background and Overarching Considerations

1. Background and context

1.1 The *Mental Health Act 2014*

The Act was the outcome of an extensive legislative reform process, which sought to:

- reflect contemporary mental health policy and practice
- align with the *Victorian Charter of Human Rights and Responsibilities Act 2006* (the Charter), the United Nations (UN) Convention on the Rights of Persons with Disabilities and the UN Convention on the Rights of the Child
- enshrine the principles of presumption of capacity and supported decision-making.

One of the fundamental objectives of the Act is to protect the rights and dignity of people accessing public mental health services in Victoria, placing them at the centre of their own treatment and care. The Act introduced a set of 12 mental health principles to which services must have regard when providing mental health services (s 11):

- a) persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred;*
- b) persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life;*
- c) persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected;*
- d) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;*
- e) persons receiving mental health services should have their rights, dignity and autonomy respected and promoted;*
- f) persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to;*
- g) persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to;*

- h) *Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to;*
- i) *children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible;*
- j) *children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected;*
- k) *carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible;*
- l) *carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.²*

These principles must also be upheld by any person performing any duty or function under the Act, which includes the MHCC.

1.2 Establishment of the MHCC

The Mental Health Complaints Commissioner (MHCC) was established under the Act as one of the key components of the improved safeguards, oversight and service improvement provisions of the legislation. The MHCC is an independent, specialist complaints body which was established in response to the extensive community consultations and legislative review processes which preceded the Act. These consultations consistently identified the need for an *'accessible, supportive and timely complaints mechanism that will be responsive to the needs of people with mental illness.'*³ The MHCC was created to address the significant barriers people experienced in making a complaint about public mental health services, and to provide a statutory mechanism to ensure that the information from complaints was used to drive improvements in the safety and quality of services. It is a unique feature of Victoria's mental health system.

The Act gives the MHCC the following key functions⁴:

- (a) to accept, assess, manage and investigate complaints relating to mental health service providers;*
- (b) to endeavour to resolve complaints in a timely manner using formal and informal dispute resolution as appropriate, including conciliation;*
- (c) to issue compliance notices;*
- (d) to consult persons or bodies for the purposes of fulfilling his or her functions under this Act;*
- (e) to provide advice on any matter relating to a complaint;*
- (f) to make the procedure for making complaints in relation to mental health service providers available and accessible, including publishing material about the complaints procedure;*

² s 11 *Mental Health Act 2014* (Vic)

³ Mental Health Bill, Second Reading Speech 20/2/2014

⁴ s 228 *Mental Health Act 2014* (Vic)

(g) to provide information, education and advice to mental health service providers about their responsibilities in managing complaints made by consumers;

(h) to assist consumers and other persons referred to in section 232(1) to resolve complaints directly with mental health service providers, both before and after the Commissioner has accepted the complaints;

(i) to assist mental health service providers to develop or improve policies and procedures to resolve complaints;

(j) to identify, analyse and review quality, safety and other issues arising out of complaints and to provide information and to make recommendations for improving the provision of mental health services to the following, as appropriate—

- (i) mental health service providers;*
- (ii) the chief psychiatrist;*
- (iii) the Secretary;*
- (iv) the Minister*
- (iv) the NDIA*
- (v) the NDIS Quality and Safeguards Commission;*

(k) at the request of the Minister, to investigate into, and report on, any matter relating to mental health service providers;

(l) to perform any other functions conferred on the Commissioner by this Act or any other Act or the regulations.'

The MHCC has 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).

As an additional oversight, all public mental health services are required under the Act to provide a biannual report to the MHCC detailing the number of complaints made directly to their service and the outcomes of these complaints.

1.3 The MHCC's role and approach

As part of the broader quality and safety oversight mechanisms in the current system, the MHCC has a key role in safeguarding the rights of people accessing public mental health services, upholding mental health principles of the Act, and recommending service and system improvements. The MHCC's approaches were developed through extensive input and consultations with consumers, families, carers and services during the establishment of the office. The value of the MHCC's role and a specialist approach to mental health complaints is discussed below in 1.5.

In summary we work to:

- safeguard the rights and dignity of individuals, families and carers
- resolve complaints in ways that uphold people's rights and support their recovery
- support services to develop effective complaint resolution processes
- use information from complaints to address issues of rights, quality and safety issues and achieve service and systemic improvements

In carrying out our complaint resolution functions, we assess every complaint with reference to the Act, with a particular focus on the mental health principles and ensuring rights are recognised, promoted and upheld.

We work to resolve complaints in ways that:

- **safeguard rights**, promoting awareness of people's rights and compliance with the Act and the Charter
- **support recovery**, ensuring people are heard and respected and feel confident that their views and preferences have been appropriately considered
- **improve services**, ensuring compliance with the Act and identifying opportunities to improve services
- **improve individual experiences**, providing a person-centred process that works to reduce fears and build the confidence and relationships needed for a person to raise concerns directly with the service
- **aim to prevent a recurrence of issues**, both for the individual concerned and for others.

In striving to achieve these outcomes, we support consumers, families, and carers to raise their concerns or make a complaint directly to the service or our office. We aim to provide accessible, tailored and flexible resolution processes, both informal and formal, that respond to the unique and diverse needs of people receiving 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 a vital role in improving people's experiences and supporting their journey towards recovery and wellbeing.

We also undertake investigations into matters involving risk and safeguarding concerns identified in complaints and make recommendations for service and system improvements and remedial actions by services. We use the range of our powers and functions under the Act to effect change and to promote and protect the rights of consumers, including through the receipt and monitoring of legal undertakings by services.

As part of our oversight and service improvement functions, we receive and analyse data from public mental health services about the complaints they receive and the outcomes of these complaints, and we work with services to address the issues we identify. Our team strives to build the capacity of services to develop a positive complaints culture, where services provide effective responses to complaints and people feel supported to speak up. Where appropriate, we encourage and support early, local resolution of complaints between the person and the service.

The MHCC has an explicit function under the Act to '*identify, analyse and review quality, safety and other issues arising out of complaints and to provide information and make recommendations for improving the provision of mental health services*'⁵, as well as broad

⁵ s 228(j) *Mental Health Act 2014* (Vic)

functions to provide advice to mental health service providers on any matters relating to complaints⁶. To this end, we make recommendations arising from individual complaints and investigations, as well as undertaking strategic projects such as the sexual safety project which is discussed in 1.5 below. These recommendations and projects enable us to share the lessons learned through complaints and investigations, and our analysis of complaints data and themes and to use these to drive broader service and system improvements. A summary of the recommendations made to the Secretary of the Department of Health and Human Services and the Chief Psychiatrist under s228(j) of the Act on specific issues of quality, safety and rights identified in complaints and investigations is provided in Appendix B.

In considering the impacts of the MHCC's role and approach, it is important to note that the MHCC's capacity to conduct investigations, undertake data analysis and strategic projects, and education and engagement activities, has been limited by budget constraints. We have needed to prioritise resources to respond to the volume and complexity of complaints over the MHCC's first five years of operation. The MHCC will be able to increase its capacity to perform its safeguarding, oversight and service improvement functions through the additional budget allocations to the MHCC for 2019-20 and 2020-21 that were announced in the Victorian Government's 2019-20 budget.⁷

It is also important to note that the MHCC does not have powers and functions to conduct own motion investigations, independently review critical incidents in services without a complaint or inspect a service without an investigation. Such powers are available to oversight bodies in other jurisdictions such as the Disability Services Commissioner.⁸ The absence of these powers and functions limits the options and information available to the MHCC in the performance of its safeguarding, oversight and service improvement roles when compared to the equivalent roles performed by the Disability Services Commissioner. The MHCC does not, for example, have access to incident reports on alleged assaults in mental health services to be able to compare the types and numbers of these incidents with the complaints received about these matters. The MHCC has endeavoured to maximise the performance of its safeguarding, oversight and service improvement roles through information-sharing, referrals and collaboration with the Chief Psychiatrist and the other quality and safety oversight mechanisms within the current system (see discussion in Part B 4.1 for examples on sharing of complaints data for quality and safety purposes).⁹

⁶ s 228(e) *Mental Health Act 2014* (Vic)

⁷ *Victorian Government, Victorian Budget 19/20, Service Delivery Budget Paper No. 3*, pp51 & 59; the MHCC received additional budget allocations of \$1.2 m in 2019/20 and \$1.3 m in 2020/21, to the MHCC's base budget of \$2.878 m. From 2016/17 to 2018/19, the MHCC received additional fixed term funding from DHHS to respond to specific demands and conduct investigations.

⁸ *Disability Act 2006*; see <<https://www.odsc.vic.gov.au/about-us/what-we-do/#oversight>>

⁹ Increased options for information-sharing for quality and safety oversight purposes are anticipated through proposed legislative amendments as part of the implementation of the recommendations of the DHHS report *Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care* 2016.

1.4 The MHCC's Advisory Council

The MHCC established an Advisory Council to ensure that our work is informed and driven by people with lived experience as consumers, families and carers, and people with experience working in mental health services. The Council members draw on their unique personal or professional experience and knowledge to provide us with strategic advice and insight. They also help to inform changes to our practice and participate in our projects. 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
- three people with experience of working in mental health services.

Consistent with its role, the Advisory Council has been actively engaged in the development of this submission, particularly in identifying the overarching considerations in respect to the questions posed by the Royal Commission, which are outlined below.

1.5 The value of a specialist approach to mental health complaints

When we started operation in 2014, Victoria became the first and only Australian state to establish a specialist mental health complaints body. Since the MHCC was established, Victoria has recorded significantly more mental health complaints than any other jurisdiction and has been highlighted nationally as an example of the advantages of a specialist approach to mental health complaints.¹⁰

The establishment of the MHCC has given Victorians the opportunity to share their experiences of mental health services, and to have their concerns heard and responded to. We do this by using information from complaints to systematically identify key areas of service provision which require actions by both services and the department to address quality and safety issues and achieve service and systemic improvements. An example is the MHCC's sexual safety project and report *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report March 2018*¹¹ which outlined a comprehensive set of recommendations and actions to address the significant risks and incidents of sexual safety violations that were identified in complaints. These recommendations are listed in Appendix C.

The *Right to be Safe* report demonstrated how complaints can provide a vital window into the gravity and impact of people's experiences, and the actions needed to ensure personal safety and rights are upheld. This report, along with our work in identifying and addressing other significant avoidable harms in mental health services, highlighted the need for committed actions to ensure people are and feel safe when accessing mental health treatment.

¹⁰ Australian Commission on Safety and Quality in Health Care, *Vital signs 2017: the state of safety and quality in Australian health care*, ACSQHC, Sydney 2017, pp 32-35.

¹¹ Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report March 2018* <<https://www.mhcc.vic.gov.au/resources/publications>>

The gravity of the issues identified in complaints to the MHCC, particularly those involving breaches of the Act, rights violations and avoidable harms, demonstrate the critical need for the safeguarding and oversight functions of our office.

Themes in 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 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 and support of the role of family members, carers and other support people play in the recovery and wellbeing of consumers.

The MHCC has observed 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, 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 that 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.

Since commencing in 2014, the MHCC has gathered a quantum of information and insights from thousands of people with personal experience of accessing mental health services, that wasn't previously available. It is essential that this information is used to improve people's experiences and to inform the broader reforms of mental health system, both now and into the future.

1.6 Overview of number and types of complaints to the MHCC

The annual number of enquiries and complaints made to the MHCC has increased each year since 2014, rising from 1,456 enquiries and complaints received in 2014-15 to 2195 in 2018-19 (9261 across the five years of operation). These numbers are four to five times higher than the original resource modelling used to establish the office, and approximately seven to 10 times higher than the number of complaints about public mental health services that are received by health complaints bodies in other jurisdictions.¹² This quantum should be attributed to the value of having an accessible and specialist avenue for people to raise their concerns about experiences with mental health services. In interpreting these figures, it is also important to note that research about complaints across a range of settings indicates less than four per cent of people who are dissatisfied about a service will make a complaint.¹³

¹² See for example *Health Care Complaints Commissioner NSW Annual Report 2017-18* pp19-20 which records 128 complaints about mental health care in public hospitals and 77 complaints about psychiatric units; See also *Health and Disability Service Complaints Office WA Annual Report 2017-18* which records 349 mental health complaints including complaints about private providers.

¹³ See discussion of this research in Disability Services Commissioner, *Good practice guide and self audit tool*, Second Edition September 2013: pp18-19

Given the known fears and barriers to making a complaint about a mental health service, it is reasonable to assume that the complaints received by the MHCC are likely to be representative of the experiences of a much larger number of people who had similar experiences but did not make a complaint.

It is noteworthy that consumers raise the majority of complaints and enquiries with the MHCC, accounting for roughly 70 per cent of complaints and enquiries over the five years of our operation, with family members and carers raising approximately 25 per cent of complaints and enquiries.

At least 95 per cent of complaints and enquiries in each year of the MHCC's operation have been about designated mental health services, while the remainder relate to mental health community support services. The consistent higher proportion of complaints about designated mental health services is likely because of the significantly higher numbers of consumers accessing these services and that consumers may be subject to compulsory assessment or treatment orders.

Of the complaints about designated mental health services, the proportion of complaints about different services or program types have been relatively consistent each year. Approximately 80 per cent of these complaints are about adult mental health services, and of these, almost 60 per cent are about inpatient services. Community mental health services (including community care units and prevention and recovery care services) have typically accounted for 35-40 per cent of complaints and enquiries about adult clinical mental health services.

An overview of the MHCC's complaint data is provided in Appendix A, and specific examples of complaint themes and issues are provided in Part B of this submission. The detailed list of complaint issue categories that is used in the MHCC's complaint data management system is provided in Appendix D. This list shows the breadth and diversity of issues raised in complaints to the MHCC.

2. Overarching considerations for the Royal Commission

2.1 The importance of being driven by lived experience

Themes in complaints to the MHCC indicate that, despite rights-based mental health legislation, people frequently have experiences where their right to make decisions about their treatment is not supported, which has significant and lasting negative impacts on their mental health and recovery. Many people also report that the treatment provided in public mental health services is dominated by a medical model that does not reflect people's views and preferences for treatment or their lived experience and expertise.

To avoid replicating the dynamic that many people have experienced in services, and to provide the best opportunity for the Royal Commission to make recommendations that will respond to the self-identified needs of consumers and carers, it is critical that the lived experience of consumers and carers informs every stage and level of the Royal Commission process. The MHCC notes the requirement in the Terms of Reference for the Royal

Commission to have regard to the evidence of people with lived experience in the formulation of its recommendations.¹⁴ To realise the goal of achieving ‘*sustainable outcomes that enhance the lives of people who experience mental illness.... and Victoria’s mental health system*’,¹⁵ the Royal Commission’s recommendations need to be informed and driven by the experiences of people with mental health issues and mental illness, their families and carers, particularly in assessing what interventions are effective in developing a rights-based mental health and broader service system that meaningfully supports recovery.

To support this goal, the MHCC’s submission has been developed in collaboration with our Advisory Council, comprised of consumers, carers and people with experience of working in mental health services.

2.2 Safeguarding rights within the mental health service system

The MHCC was also pleased to see the requirement in the Terms of Reference for the Royal Commission to have regard to ‘*the need to safeguard human rights, promote safe and least restrictive treatment and to ensure the participation of people with lived experience in decision-making that affects them*’¹⁶.

In preparing for this submission, our Advisory Council members were asked about the vision that they wanted to put forward to the Royal Commission for a reformed mental health system. A key priority put forward by our Advisory Council members was the need to prevent the violations of human rights that can occur within the current mental health system and to consider the roles that legislation, systems and culture play in the provision of services. Despite having mental health legislation that provides strong protections and safeguards for people experiencing mental health challenges and illness, complaints to the MHCC have highlighted significant breaches of people’s rights and avoidable harms while in the care of or attempting to access mental health services. Examples are provided in Part B of this submission.

These harms include suicide and self-harm, injury and trauma occurring due to physical or sexual assault, as well as physical and psychological harms and trauma because of the use of coercion including compulsory treatment and restrictive interventions. Complaints show that consumers have experienced violations of their physical, sexual and psychological safety while receiving acute mental health inpatient treatment. Understanding the consumer perspective of the harms that occur within mental health services, including trauma and re-traumatisation, is critical to ensuring that people can receive treatment that is helpful in their recovery and to engage with the services they need to support their ongoing recovery, including hospital treatment when needed.

As indicated in the introduction to this submission, complaints to the MHCC indicate significant issues and gaps in the extent to which services practices reflect the requirements

¹⁴ Royal Commission into Victoria’s Mental Health System, Letters of Patent February 2019, sIII (a)

¹⁵ Ibid, sIII

¹⁶ Ibid sIII(g)

and principles of the Act, or compatibility with the Charter. There is a pressing need for increasing compliance with the Act and its underpinning human rights principles, including respecting people's autonomy and dignity, supported-decision making, least restrictive treatment options, recognising and responding to the culture of identity of Aboriginal people, and people's individual needs of culture, language, age, disability, religion, gender or sexuality, medical and other health needs, and the role of families and carers.

Achieving a mental health system that safeguards human rights requires staff at all levels to have a deep understanding and commitment to human rights as a core foundation of their work. The MHCC's work with clinicians and services has identified significant gaps in knowledge and understanding of people's rights under the Act and the Charter and the mental health principles. To move from a system that makes decisions for people rather than with them, it is necessary for services to develop cultures that:

- understand and prioritise physical, psychological, emotional, spiritual and cultural safety
- know that this means supporting people to understand and exercise their rights, and have choices about their treatment
- understand that this means implementing systems and approaches that will reduce or eliminate the use of restrictive interventions and other forms of coercion

It is essential that the views and experiences of consumers, families and carers drives decisions about the kinds of services that are provided to prevent crises, to respond early when a crisis occurs and to best support recovery. The Royal Commission has already demonstrated a commitment to hearing people's stories about what is not working in the current service system and what is missing, their experiences of harm and trauma, and their visions for a reformed mental health system. It is important that lived experience perspectives are also central to the development of improved safety and quality indicators for mental health services that identify measures that will ensure adequate oversight of the issues that consumers, families and carers see as most important to providing safe, quality care and treatment. These issues may be different to the kinds of issues that are currently measured and may include, for example:

- public reporting of alleged physical or sexual assaults occurring in mental health services, as well as
- developing measures about the extent to which people feel their views were respected and supported during their treatment
- developing measures about the extent to which mental health services seek to engage and work with families and carers.

It is also essential that people's right for protection from 'cruel, inhuman or degrading treatment'¹⁷ under both the Charter and the *UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* underpins the Royal Commission's recommendations for safeguarding people's rights within a reformed mental health system. The MHCC has highlighted the ways in which Australia's ratification and implementation of

¹⁷ *Victorian Charter of Human Rights and Responsibilities Act 2016*, s10

the Optional Protocol to the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT)¹⁸ creates both an increased obligation and imperative for mental health services to take preventative actions against treatment that is experienced by consumers as being ‘cruel, inhuman or degrading’, torture or punishment, particularly in closed environments and in the use of restraint or seclusion.¹⁹

2.3 Developing a mental health system as part of a healthy community

The Royal Commission is a once in a generation opportunity to develop a mental health system that reflects and supports a mentally healthy Victorian community. The MHCC notes that mental wellbeing or ill-health does not occur in isolation but as part of the broader community and as such, we welcome the Royal Commission’s focus on improving the social and economic participation of people experiencing mental health challenges and mental illness. We note the impact of the broader social determinants of health on people’s mental wellbeing, including access to safe and secure housing, access to education, financial independence, freedom from violence, and freedom from discrimination, and strongly support the focus on strengthening links between mental health services and the services that support people to live a safe and meaningful life with or without symptoms of mental illness.

To support a mentally healthy community, mental health treatment and support must also better seek to involve people’s existing support networks in treatment. Themes in complaints to the MHCC show that families and carers are not always provided with the information they need to provide support to their loved one, nor are their own needs consistently identified and met by services. Where people do not have strong existing support networks, systems need to step in to provide the supports that people need to become and stay well and participate in community life. Complaints to the MHCC demonstrate that this does not always occur for a number of reasons including insufficient treatment planning, lack of locally available services, or poor links between mental health services, other support people such as families and carers, and relevant support services.

For all people to be part of a mentally healthy community, barriers to accessing the mental health system must be addressed. Accessibility and a lack of culture safety and appropriateness of services for various communities (including Aboriginal Victorians, culturally and linguistically diverse people, refugee and asylum seeker communities, LGBTI communities, women, people with disabilities, younger and older people) may mean that people either do not seek services, are not able to access appropriate services, or have negative experiences in services that result in poorer mental health and/or reluctance to access these services in future.

¹⁸ United Nations’ *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* opened for signature 18 December 2002, 2375 UNTS 237 (entered into force 22 June 2006); Australia ratified OPCAT on 21 December 2017 and has three years to implement independent monitoring and inspection visits of places of detention and closed environments where people may be deprived of liberty.

¹⁹ See discussion in Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018, p24; See also MHCC keynote presentation on OPCAT at the 12th National Forum on ‘Towards Eliminating Restrictive Practices’ (TERP).
<<http://www.terpforum.com/wp-content/uploads/2018/11/1430-COULSONBARR-Thursday.pdf>>

To achieve a healthy community, issues of stigma must also be addressed. While stigma is a community wide issue, this submission focuses on people's experiences of stigma within health services (including emergency departments) and within mental health services.

PART B: Responses to specific questions posed by the Royal Commission

1. Suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination (Q1)

It is clear from the MHCC's work with consumers, families, carers and services that people experiencing mental health issues and mental illness experience significant stigma, which should be more accurately described and understood as discrimination. People with mental health issues and mental illness can experience discrimination and stigma across all aspects of public life, such as accommodation, education, health services and employment, which has negative mental health consequences. Addressing the root causes of discrimination and stigma is therefore critical to both primary prevention strategies and mental health service delivery.

As noted in Part A above, the MHCC's observations on the prevalence of stigma and discrimination focus on people's experiences within health services (including emergency departments) and within mental health services. The pervasive nature of discriminatory attitudes towards people experiencing mental health challenges and mental illness, can be seen in the rejection people can experience when presenting to emergency departments in distress, through to the use of language that is commonly found in clinical records. The impact of stigma and discriminatory attitudes within the mental health service system can also manifest in people with mental health issues and mental illness experiencing a lack of compassion in their treatment. Given that people accessing mental health treatment are likely to have a background of previous trauma, experiences of rejection by services and a lack of compassion can have a profound effect not only on their mental health journey but on their lives. It is not uncommon for people who have received such treatment to tell the MHCC that they will never voluntarily seek mental health services again. In many cases people have a window of opportunity of willingness to seek assistance from services which is time sensitive and dependent on an empathic and supportive responses from staff.

Examples of complaints to the MHCC includes people's concerns that they have been refused assistance from emergency departments or an admission to a mental health service because of a diagnosis of Borderline Personality Disorder or a substance abuse problem (see further points in sections 4.2 and 4.3 below). Complaints about people's experiences of long waiting times in emergency departments when seeking mental health treatment or attending on an Assessment Order²⁰, and the use of restraints for periods including overnight whilst waiting for a medical review and/or an inpatient bed, can also be seen as discriminatory in terms of the lack of urgency demonstrated in response to people's mental health presentations and to the deprivation of people's liberty in these environments. Further examples are discussed in 4.4 below.

²⁰ An Assessment Order made under section 28 of the Mental Health Act 2014 provides for a person to be compulsorily taken to, and detained in, a designated mental health service and examined to determine whether the criteria for a compulsory temporary treatment order applies.

Other examples include complaints about medical and other physical health conditions not being assessed or treated due to what is called the 'diagnostic overshadowing' that occurs when people have a diagnosis of mental illness. This is essentially a discriminatory practice of attributing physical health symptoms to a mental health condition without appropriate assessment.²¹ In addition complaints to the MHCC have identified many examples of people's physical health needs not being met during admissions to acute mental health inpatient units which are discussed at 4.10 below. This is particularly concerning given the well documented and alarming rates of poor physical health outcomes for people with mental illness compared to others in the general community, along with increased rates of morbidity and mortality and lower life expectancy of about 20 years.²²

In respect to attitudes associated with mental health treatment, the MHCC continues to observe references to consumers 'absconding' from services or being 'non-compliant' with treatment which are essentially punitive terms to describe people's actions of leaving a service without agreed leave or not wanting to take a particular medication. These terms can be used regardless of whether or not someone is voluntarily seeking treatment or has expressed concerns about the nature of treatment or side effects of the medication. The continued use of such terms without thought for the implied judgements or lack of regard for a person's autonomy, points to the need to address the underlying attitudes and cultures that were expected to change through the implementation of the Act. There are many language guides that have been developed by consumer groups and mental health organisations to provide non-stigmatising and non-discriminatory alternatives to terms and expressions that are experienced as harmful and exclusionary by consumers.²³ Victoria's implementation of the *Safewards*²⁴ program in acute mental health inpatient units has identified alternative words and phrases that can be used by nurses in services to engage with consumers and de-escalate situations, which could form the basis of a broader awareness raising amongst clinicians of negative meanings behind some of the common language used in services.

The most concerning examples of discriminatory attitudes within mental health services, are those where consumer's allegations of sexual harassment or sexual assault have not been believed or acted upon by services because they were attributed to a person's delusions or symptoms rather than assessing the available evidence or considering whether allegations could be based in fact even if some of the allegation appears unusual or implausible.²⁵ The prevalence of these issues within the broader community and within law enforcement and

²¹ These issues were highlighted at the recent '2019 National Equally Well Symposium' which focused on strategies to address the poor physical health outcomes for people living with mental illness. <<https://www.equallywell.org.au/event/equally-well-symposium/>>. The need for such strategies was recognised in the development of the framework for mental health services titled 'Equally well in Victoria' March 2019: <<https://www2.health.vic.gov.au/about/publications/policiesandguidelines/equally-well-in-victoria-physical-health-framework-for-specialist-mental-health-services>>

²² Firth, J et al 'The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness' The Lancet Psychiatry Commission, Volume 6, Issue 8 pp675-712, 2019

²³ See for example Mental Health Coordinating Council 2018, The recovery- orientated language guide, viewed 12 December 2018, <http://www.mhcc.org.au/wp-content/uploads/2018/05/Recovery-Oriented-Language-Guide_2018ed_v3_201800418-FINAL.pdf>. This guide includes examples of using language of choice such as 'Sam is choosing not to take medication/attend appointments' rather than 'Sam is non-compliant'

²⁴ <https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards>

²⁵ Ashmore T, Spangaro J and McNamara L 2015, 'I was raped by Santa Claus: responding to disclosures of sexual assault in mental health inpatient facilities', *International Journal of Mental Health Nursing*. 2015 Apr;24(2):139-48.

judicial systems has been well documented,²⁶ and still require concerted efforts to ensure that the Charter right of equality before the law²⁷ is consistently upheld for victims of crime who have a mental illness. These issues were highlighted in the MHCC's *Right to be Safe* report, along with examples of changes in practices of services to report all alleged and suspected sexual assaults and proactively engage with their local police.²⁸ The recommendations made in the *Right to be Safe* report in relation responding and reporting of alleged sexual assaults highlighted the importance of addressing discriminatory attitudes within the mental health system and in services' interactions with Victoria Police.²⁹

In addition, the MHCC observes that the pervasive nature of stigma and discrimination in the community continues to negatively impact on both people's wellbeing and their preparedness to access mental health services or raise concerns about their experiences within mental health services.

It is therefore important to make sure that any strategies that aim to reduce stigma and discrimination address both broader community attitudes, and the specific manifestations of those attitudes within the health and mental health systems where such attitudes can result in adverse outcomes for people who are seeking or receiving services.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support (Q2)

While primary prevention strategies for mental illness are outside the scope of the MHCC's role, the MHCC's experience with complaints and its education and engagement work points to the critical role of people feeling supported to speak up about their concerns and having confidence in responses that they will receive if they seek help. As discussed in Part A, it is also critical to consider the broader social determinants of health on people's mental wellbeing, including access to safe and secure housing, access to education, financial independence, freedom from violence, and freedom from discrimination. The MHCC's education and engagement work with Aboriginal Victorians, refugee and asylum seeker communities, LGBTI Victorians and people with disabilities, has highlighted the high rates of mental health issues and mental illness in these communities which can be directly linked to experiences of discrimination, violence and exclusion, along with complex trauma. Primary prevention strategies therefore need to be targeted to address these profound underlying causes and risk factors.

Prevention also needs to be considered in broad terms of preventing further episodes of mental health issues and mental illness and removing the barriers to people seeking treatment and support. These barriers include negative experiences and trauma associated

²⁶ See for example <<https://www.humanrightscommission.vic.gov.au/our-resources-and-publications/reports/item/894-beyond-doubt-the-experiences-of-people-with-disabilities-reporting-crime>>

²⁷ Section 8, Victorian Charter of Human Rights and Responsibilities Act 2016

²⁸ Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018; , See discussion and recommendations in Section 2.5.3 'Reporting suspected and alleged sexual assaults to Victoria Police', pp 88-95.

²⁹ Ibid

with seeking or receiving mental health treatment, which will be discussed further in sections 3 and 4 below. This includes consideration of how a system can better minimise and avoid the use of coercion, reduce or eliminate restrictive treatment practices, as well as how people can be better supported to understand and exercise their rights, including making and participating in decisions about their treatment (supported decision making).

Complaints to the MHCC also highlight the barriers that particularly families and carers experience in trying access support, especially outreach support, for people who may be reticent or opposed to engaging with mental health services. These issues will be discussed further in 4.2 and 6 below. Themes in complaints about the types of treatment provided in services point to the limited choice in treatments, particularly the limited availability of non-biomedical options, which can also become a disincentive for people to seek early treatment and support when experiencing episodes of mental health issues or mental illness in the future. The importance of choices in treatment is discussed further in 4.5 below.

3. What is already working well and what can be done better to prevent suicide (Q3)

It is beyond the scope of the MHCC's role and experience to comment on the effectiveness of suicide prevention strategies at community or population levels. Complaints to the MHCC however point to specific areas within public mental health services that must be addressed to prevent suicide among people who have had contact with these services. It is important that approaches to suicide prevention consider the continuum of people's experiences and include strategies which address the nature of their interactions and experiences with mental health services. It is also critical that suicide prevention strategies are prioritised and codesigned with those groups within our community with higher rates of mental illness and suicide than the general community, such as Aboriginal and LGBTI Victorians, particularly younger and trans and gender diverse members of these communities (see discussion in section 5).

As will be discussed below in section 4.1, it is clear that adverse experiences of seeking and receiving treatment within the public mental health system can cause significant trauma and harms that have long lasting negative impacts on people's wellbeing and willingness to seek help in the future. Complaints to the MHCC point to the need to prioritise actions and changes that will prevent such harms from occurring as a consequence of treatment. This is captured clearly in this complaint about a consumer's experience of being restrained in an emergency department:

"The whole experience has done untold damage to my state of mind... the hospital only succeeded in providing an experience so traumatic that I will never again go to a hospital if I have feelings of suicide."

Such experiences equally affect the willingness of families and carers to seek support and assistance from mental health services. The significant impacts of adverse events and avoidable harms in emergency departments and acute mental health inpatient units are discussed further in sections 4.3 to 4.10 below. While experiences such as the use of restrictive interventions have clear negative impacts on people's preparedness to seek future

help from mental health services, complaints to the MHCC about rudeness or the lack of empathy and compassion from staff have also highlighted how these interactions can escalate people's distress and suicidal feelings and have the same negative outcomes on future help seeking.

The MHCC has also dealt with complaints involving the devastating tragedies of suicides of people who have accessed or attempted to access public mental health services.

Themes from these complaints include the critical need for mental health services to:

- work more closely with families and carers in listening and responding to their concerns about their loved one to facilitate faster assessment and treatment
- improve discharge planning processes to ensure that families and carers are involved in, and can contribute their views to the discharge plan
- address the negative experiences of treatment which can lead people to avoid seeking treatment in the future
- ensure shared care arrangements between public and private clinicians are effective and responsive
- improve understandings of trauma and trauma-informed care to help people to feel safe and willing to access mental health services when required

In dealing with complaints involving suicides of consumers, the MHCC's practice is usually to review the coronial finding and the outcome of the service's Root Cause Analysis (RCA) review and assess whether there are outstanding issues that are appropriately considered by the MHCC. Where appropriate the MHCC may make recommendations to the service for further service improvements.

Approaches to suicide prevention also need to consider the range of settings in which people may express suicidal feelings or be assessed as being at risk of self-harm and suicide, and the need for appropriate mental health responses and treatment. Of particular concern are the approaches adopted in youth justice centres and prisons, given the high rates of mental illness of detainees and prisoners and the use of 'solitary confinement'³⁰ in response to assessed suicide risks. The extremely harmful nature of these practices and the pressing need for appropriate mental health treatment for young people and prisoners assessed as being at high suicidal risk is being examined in a current 'OPCAT' style investigation by the Victorian Ombudsman.³¹ The MHCC has contributed to this investigation as a member of the Advisory Group and member of the inspection team. The findings and recommendations of this report will offer critical insights for the Royal Commission's formulation of recommendations in respect to suicide prevention and the broader considerations of ensuring appropriate mental health treatment and care in places of detention.

³⁰ 'Solitary confinement' is defined in the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) Rule 44 as 'the confinement of prisoners for 22 hours or more a day without meaningful human contact'. This can include practices referred to as 'lock downs', 'separations', 'seclusion' and 'time-outs'.

³¹ See details in media release by the Victorian Ombudsman 'Ombudsman to investigate the use of 'solitary confinement' and young people' December 2018 and 'Victorian facilities that will be inspected regarding the use of 'solitary confinement' and young people' March 2019 <<https://www.ombudsman.vic.gov.au/News/Media-Releases/>>

4. What makes it hard for people to experience good mental health and what can be done to improve this- including how people find, access and experience mental health treatment and support and how services link with each other (Q4)

4.1 Overview of issues and themes from complaints

The themes from complaints to the MHCC highlight the significant challenges that consumers, families and carers can experience in their interactions with mental health services. Adverse experiences of seeking and receiving treatment within the public mental health system not only make it hard for people to experience good mental health but can cause additional trauma and harms that have long lasting negative impacts on people's wellbeing and future help seeking. The incidences of avoidable harms and trauma that have been identified in complaints to the MHCC, such as sexual safety violations in acute inpatient units as highlighted in the *Right to be Safe* report,³² point to the need to prioritise actions and changes that will prevent such harms from occurring as a consequence of treatment. As outlined in the overarching considerations in this submission, actions to improve the way in which people can experience good mental health need to firstly address the current risks of human rights violations and avoidable harms that people can experience in the public mental health system.

Complaints to the MHCC have also highlighted the critical importance of compassionate and trauma informed care for improving people's experiences and outcomes of mental health treatment. Whether or not people have experienced compassion and empathy from mental health clinicians and staff can be a key determinant of how they feel about their treatment and the extent to which they are supported in their recovery. Complaints from consumers, families and carers point to the need to recognise the importance of the human and relational dimension of mental health treatment and care, and the need for person-centred, holistic and inclusive approaches, while at the same time as addressing the broader issues of system design and resourcing.

The outcomes of complaints to the MHCC have also highlighted the importance of accessible and supportive complaints processes, and the difference that a positive resolution of a complaint can make to a person's wellbeing and recovery and future engagement with services. Conversely, unresolved issues about a person's experience of mental health treatment can become a real barrier to their recovery and future help seeking.

There are many specific issues relating to accessing services, experiences of treatment and linkages to other services that have been raised in complaints to the MHCC since 2014, as well as those identified in the local complaint reporting data.³³ Given the volume and diversity of complaints received by the MHCC, this submission does not attempt to cover all the issues identified in complaints or provide individual examples. Most complaints involve more than one issue and any of the issues raised could arguably be regarded as factors which can

³² Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018

³³ The MHCC can provide more detailed examples and data on request.

make it hard for people to experience good mental health and indicative of areas for improvement. The breadth of issues identified in complaints is shown in the full list of the MHCC's complaint data management issue categories provided in Appendix D.

Since the start of operation, the MHCC has reported on complaint issues under the following broad categories in the Victorian Hospital Incident Management System (VHIMS)³⁴ which is used by Victorian public health services, including public mental health services, and provided analysis and commentary on the types of issues identified under each of these categories:

- *Treatment*
- *Communication, consultation and information patterns and frequency*
- *Staff behaviour, competence and professional conduct*
- *Medication*
- *Access*
- *Environment, personal safety and management of the facility*³⁵

Complaints most often involve more than one issue and issues are therefore reported on a frequency of how often they are identified in complaints. The patterns and frequency of issues have been reasonably consistent from 2014 to 2019. The following summary provided in the MHCC's 2018 Annual Report provides an overview of the patterns and frequency of issues under these broad categories:

In 2017–18 treatment continued to be the most common issue identified in new complaints (55 per cent). Consistent with overall trends in previous years, the next most common issue was concerns about communication, consultation and information (raised in 41 per cent of new complaints) followed by issues about staff behaviour, competence and professional conduct (22 per cent) and medication (19 per cent).

Other frequently occurring issues in 2017–18 included specific issues about access to services (14 per cent), environment, personal safety and management of the facility, which included concerns about sexual safety (nine per cent), and discharge and transfer arrangements (nine per cent).

*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.*³⁶

The MHCC's annual reports provide breakdowns and discussion of the types of issues identified under each of these categories, including high level comparisons between MHCC complaint data and the local complaint reporting data from services. The MHCC is currently finalising individual service provider reports which show comparative data over three years

³⁴ For information on VHIMS see < <https://www.bettersaferecare.vic.gov.au/our-work/incident-response/VHIMS>>

³⁵ MHCC Annual Reports 2014/15, 2015/16, 2016/17, 2017/18; See discussion of complaint issues under sections on 'Safeguarding rights and resolving complaints'.

³⁶ See MHCC Annual Report 2018 pp 21-24; See also Appendix A for further examples of MHCC complaint data.

from 2015-16 to 2017-18. These reports include comparisons between MHCC complaint data and sector wide complaint data reported by services as well as comparisons at an individual service level. The reports also aim to enable services to identify key areas for attention and to inform service improvements.³⁷

Further work has also been done over the past year to capture more details of the specific issues experienced in mental health services, including issues relating to the provisions and principles of the Act and the Charter. Some of this data will be reported in the MHCC's 2019 Annual Report and will progressively be used to inform our service improvement functions and education work with services. The MHCC will also be sharing key insights from this data through the broader quality and oversight mechanisms that are being developed with DHHS, the Chief Psychiatrist, Safer Care Victoria and the Victorian Agency for Health Information (VAHI).³⁸

The MHCC annual reports also provide information and discussion on the numbers and broad range of service improvement initiatives and recommendations that have been made as an outcome of complaints to the MHCC.³⁹ Over the past two years, service improvement activities have included legal undertakings by services to take remedial actions to address issues of compliance with the requirements and principles of the Act.⁴⁰ The MHCC has also reported on the recommendations made to the Secretary of DHHS and the Chief Psychiatrist on specific issues of quality, safety and rights identified in complaints and investigations, and the responses to these recommendations.⁴¹ A summary list of these recommendations are provided in Appendix B.

Rather than repeating the information available in the MHCC's annual reports, the following specific themes from complaints have been chosen to respond to the question '*what makes it hard for people to experience good mental health*'. These themes highlight key factors which have a negative impact on people's experience with mental health services, and identify priority areas for consideration:

- Access to services and crisis responses
- Access and treatment in emergency departments
- Use of restrictive interventions
- Rights, autonomy and choice in treatment and supports
- Least restrictive treatment
- Trauma informed care
- Sexual safety in acute mental health inpatient units
- Quality and safety and avoidable harms
- Physical health, disability and alcohol and other drugs needs

³⁷ Examples of these reports could be provided when finalised.

³⁸ These mechanisms currently include quarterly governance meetings with DHHS Mental Health Branch and the Office of the Chief Psychiatrist, membership of Safer Care Victoria's Mental Health Clinical Network 's 'Data and Insights Committee' and pending contributions to VAHI's working group on the mental health editions of the 'Inspire' data reports for health services.

³⁹ See sections on '*Promoting service and system improvements*' in MHCC Annual Reports.

⁴⁰ See discussion in MHCC Annual Report 2018 p

⁴¹ Section 243(e) of the Mental Health Act 2014 provides for the Commissioner to accept undertakings from a service '*to take remedial action in relation to a complaint*'. Examples of undertakings and actions required by services will be provided in the MHCC's annual report for 2018-19.

- Holistic, inclusive and recovery-oriented treatment
- Service linkages and pathways.

4.2 Access to services and crisis responses

Complaints about specific issues of accessing mental health services have grown from 11 per cent in MHCC's first year of operation to 15 per cent of all complaints in 2017-18. However, these proportions of complaints do not reflect the extent of issues experienced by consumers, families and carers as it is not uncommon for negative experiences of responses to help seeking or crisis situations to be a backdrop to complaints about treatment, which constitute the largest proportion of complaints (61 to 69 per cent of complaints).⁴²

Specific issues identified in complaints about access to services and crisis responses that highlight areas for systemic change and improvement include:

- the limited availability of alternative options to inpatient admissions, such as Prevention and Recovery Care (PARC) services or community-based outreach services
- variability of the thresholds or assessment criteria⁴³ used by services to determine if outreach by a Crisis Assessment Team or Community Team is warranted
- responses by services to risks and concerns expressed by families and carers
- responses to people with diagnoses of Borderline Personality Disorder which limit access and supports provided, particularly in times of crises
- the need for special arrangements for a person to access services from a different catchment area⁴⁴
- the operation of catchments and variable criteria on access to specialist child and adolescent/youth mental health services⁴⁵
- decision making on Assessment Orders⁴⁶ and consideration of the least restrictive treatment options and the consumer's views and preferences, including community based, natural supports or private mental health treatment options⁴⁷
- responses by Crisis Assessment and Treatment teams (CATT) that take people by surprise and don't reflect agreed plans or alternative treatment options
- consumer's concerns that Victoria Police will be called to transport them to hospital as part of the crisis responses initiated by CATT or community mental health teams

⁴² See MHCC annual reports 2014-15, 2015-16, 2017-18.

⁴³ Complaints have included issues of assessments of people not being unwell enough or posing sufficient risk to warrant an outreach response from a CATT or community mental health team.

⁴⁴ Complaints to the MHCC have shown that even when a person has experienced significant trauma in a previous admission, arrangements still need to be negotiated to be admitted to an alternative unit, which also cannot be guaranteed in an emergency.

⁴⁵ The MHCC has dealt with complaints that reflect some of the issues identified in the recent report by the Victorian Auditor-General's Office *Child and Youth Mental Health June 2019*.

⁴⁶ See section 28 of the Mental Health Act 2014

⁴⁷ These issues are the subject of recently completed and planned investigations by the MHCC.

- the limited capacity of services to appropriately respond to the needs of people with dual disabilities and complex needs, particularly when mental health issues are assessed as being behavioural⁴⁸
- the challenges for people with psycho-social disabilities to access appropriate supports in the transition to the NDIS and risks of disengagement with services⁴⁹
- the impacts and limited options for consumers who are excluded from mental health services due to problematic substance use
- concerns about the way in which emergency departments operate as the effective 'front door' of public mental health treatment for many people (see details below).

4.3 Access and treatment in emergency departments

Since its first year of operation, complaints to the MHCC have raised consistent themes about the experiences of mental health consumers in emergency departments, including concerns about the nature of responses, the negative impacts of the environment, wait times, use of restrictive practices and the often highly traumatic nature of people's experiences. Consumers commonly describe their experience of a mental health inpatient admission as including their initial experiences in the emergency department before they are transferred to the mental health inpatient unit. Consumers also commonly speak about their fear and active avoidance of emergency departments. The MHCC's jurisdiction to deal with the complaints about emergency departments overlaps with the jurisdiction of the Health Complaints Commissioner, which has presented some challenges in taking a holistic approach to responding to people's concerns and experiences.

A further complexity relates to the arrangements that exist where mental health services are provided by a designated mental health service in hospitals that are not part of that service. For example, Melbourne Health (through NorthWestern Mental Health provides mental health services at the Northern Hospital (part of Northern Health) and Sunshine Hospital (part of Western Health). Northern Health and Western Health are not designated mental health services under the Act, and accordingly the MHCC does not have jurisdiction in relation to Northern Health and Western Health. Complaints to the MHCC about consumer's experiences of mechanical restraint and other adverse events in these emergency departments have highlighted the challenging corporate and clinical governance issues and risks in these arrangements, particularly in terms of responsibility for clinical decision making between emergency department and the mental health clinicians who are from different services. These issues and the need for stronger safeguards to ensure compliance with the Act have been subject to both service improvement recommendations and an investigation by the MHCC.

Complaints about the use of restrictive and coercive practices in emergency departments, including alleged injuries caused by security staff, prompted a recommendation to the Secretary of DHHS in June 2015 to review the reporting requirements for restrictive

⁴⁸ The MHCC has dealt with these issues in a number of complaints, including an investigation that resulted in recommendations to the service and the Secretary of DHHS on these issues. See Appendix B and also discussion in sections 4.10 and 5.

⁴⁹ The MHCC has dealt with increasing numbers of enquiries and complaints relating to NDIS funded supports and decision making in 2018-19 in the NDIS transition period and has identified a range of issues in relation to access and safeguards. See also discussion at point 5.

interventions as they relate to emergency departments, and the monitoring and oversight of these practices for compliance with the requirements of the Act.

A number of initiatives have been implemented since that time, including important research commissioned by the Chief Mental Health Nurse on restrictive practices in emergency departments,⁵⁰ the implementation of *Safewards* in some emergency departments, and establishment and piloting of new crisis hubs at six hospitals for people presenting to emergency departments with urgent mental health issues. Complaints to the MHCC however continue to highlight adverse experiences of consumers in emergency departments and significant concerns about the use of restrictive practices, particularly the use of mechanical restraint. Concerns about these types of experiences and practices have also more recently received national attention through the Mental Health in the Emergency Department Summit, hosted by the Australasian College of Emergency Medicine (ACEM) in October 2018 in Melbourne.⁵¹

Over the past year, the MHCC has undertaken two investigations into the use of restrictive practices in emergency departments, as well as pursuing undertakings from mental health services for remedial actions to address breaches of the Act in respect to the authorisation, review, and reporting requirements for the use of mechanical restraint.

Specific issues identified in complaints about emergency departments that point to the need for systemic change and improvement include:

- long waiting times without any therapeutic engagement with staff and the inappropriate nature of the environment for people experiencing mental health crises
- the prolonged use of mechanical restraint while consumers on an Assessment Order are waiting to be assessed by mental health staff or for a mental health inpatient bed, or where it is known that an inpatient bed is not available and where the use of restraint is not seen as a trigger for urgent medical review
- governance issues which lead to emergency department staff being primarily responsible for consumers' care with limited or delayed input from mental health staff
- the lack of comprehensive assessment in emergency departments and discharges without treatment, follow-up or referrals being offered
- inadequate knowledge and training of emergency department staff in relation to their responsibilities under the Act
- the lack of evidence of consideration of less restrictive options than placing a person on an Assessment Order
- the use of force by both security and clinical staff and allegations of assault with associated injuries and high levels of trauma

⁵⁰ See presentation by Dr Cathy Daniel, '*Restrictive Interventions in Victorian Emergency Departments: What is really going on?*' at TERP 12th National Forum < <http://www.terpforum.com/1861> >

⁵¹ This summit produced a Communique with a statement of seven principles to improve the care of people suffering mental health crisis across Australia, including within emergency departments. See <<https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Mental-Health-in-the-Emergency-Department-Summit>>

- the use of code greys and restraint being used on consumers without appropriate modification for the nature of the risk, for example, in relation to young women and people of slight build
- the lack of trauma informed care and debriefing following the use of restraint in emergency departments
- lack of family/carer involvement/ or consultation for collateral information and options for supporting the person and de-escalation
- lack of dignity associated with the use of restraint, such as in respect to toileting, with experiences of treatment as ‘cruel, inhumane, and degrading’⁵²
- consumers not being informed of their rights when placed on an Assessment Order and not being involved in decisions about treatment in the emergency department
- refusal of admissions without alternative options, follow up support or referrals being offered.

4.4 Use of restrictive interventions

Restrictive interventions include seclusion, physical restraint and mechanical restraint. The Act regulates the use of restrictive interventions in relation to people who are detained in a designated mental health service. The Act states that restrictive interventions may only be used after all less restrictive options have been tried or considered and have been found to be unsuitable. Seclusion may only be used if it is necessary to prevent imminent and serious harm to the person or to another person, while restraint may only be used also in these circumstances or to administer treatment or medical treatment. The Act sets out the requirements for authorising the use of restrictive interventions and for monitoring and review of consumers. The Chief Psychiatrist has also published guidelines that identify elements of best practice for the use of restrictive interventions in designated public mental health services

Complaints to the MHCC about the use of restrictive interventions demonstrate that they are highly intrusive practices that have a traumatic and enduring impact on consumers. There is widely recognised and undisputed evidence of the harm and trauma experienced by people who are subject to these interventions.⁵³ This means that strategies which aim to eliminate restrictive practices are critical to addressing avoidable harms in the current mental health system. Since publication of the ‘National safety priorities in mental health: a national plan for reducing harm’ in 2005, there has been a sustained emphasis and a national commitment to reduce the use of and eliminate restrictive practices as a priority for action for all States and Territories. These practices however still feature strongly in people’s experiences of Victorian public mental health services and raise significant human rights issues pursuant to the Charter, including the right to protection from cruel, inhuman or degrading treatment (s 10(b)) and humane treatment when deprived of liberty (s 22).

⁵² See discussion of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in section 2.2.

⁵³ See for example Melbourne Social Equity Institute (2014) *Seclusion and Restraint Project: Overview*, Melbourne: University of Melbourne

The MHCC has contributed to Victorian and national initiatives to reduce and eliminate restrictive interventions in mental health services including presentations at the national forums *Towards Eliminating Restrictive Interventions* (TERP).⁵⁴ The MHCC also notes the range of initiatives being undertaken by the Office of the Chief Psychiatrist and the Office of the Chief Mental Health Nurse, including the implementation of *Safewards* to address the rates of restrictive interventions in mental health services.

The types of issues raised in complaints about people's significant adverse experiences of restrictive interventions in emergency departments are set out above in section 4.3 and are not repeated here. Specific issues identified in complaints about the use of restrictive interventions in inpatient mental health units include the following significant concerns about decision-making and impacts of these practices:

- Insufficient evidence that less restrictive options were considered before a decision to use restrictive interventions; for example, lack of evidence of clinical engagement to explain to the person why they need medication before restraint is used to administer medication, and lack of evidence of exploring whether the consumer's carer or family can assist to avert the need for the use of restrictive interventions.
- Non-compliance with the provisions of the Act relating to the use of restrictive interventions, including in relation to authorisation, monitoring and review, notification and reporting to the Chief Psychiatrist.
- An absence of a trauma-informed approach in the use of restraint, for example, where there is no evidence that staff considered a consumer's trauma history is deciding whether it was necessary to use restraint.
- A failure to consider gender sensitive practice in the use of restraint, for example, where a woman was restrained by four male security guards.
- An absence of consideration of a consumer's physical health or frail physical state in the decision to use physical restraint, for example where a consumer has recently had abdominal surgery.
- Use of force during a restraint episode that resulted in physical injury and that indicated excessive force may have been used.
- No indication that a consumer was offered the opportunity to debrief after the use of a restrictive intervention as expected by the Chief Psychiatrist's guideline on restrictive interventions.
- No evidence that a formal systemic review of a restrictive intervention was undertaken in accordance with the Chief Psychiatrist's guideline on restrictive interventions.
- Concerns that excessive use of force may have been used to place a person in seclusion.
- Lengthy periods of seclusion in some cases over many weeks in circumstances raising concerns about the adequacy of oversight and exploration of less restrictive alternatives.

⁵⁴ These national forums are held every one to two years around Australia to contribute to the aim to eliminate restrictive practices and learn from local and national initiatives. See <<http://www.terpforum.com/home/program-2>>

- Lack of evidence of appropriate facilities, for example lack of access to adequate toilet facilities in seclusion, and no evidence of alternative options being supplied.
- Indications that services take a standard approach to restraint which does not appear to be individualised for the threat and circumstances of the individual.

Restrictive interventions where the Mental Health Act does not apply

The MHCC has also received complaints about the use of restrictive interventions in circumstances where a person is not subject to the protections and safeguards of the Act. In these cases there is also no oversight by the Chief Psychiatrist.

One situation is where restraint is used in hospitals on the basis of a duty of care. Restraint may be used in these circumstances in the emergency department or in a medical ward. It is a welcome development that since 1 July 2019 hospitals need to notify Safer Care Victoria if serious harm or death is caused by the use of physical or mechanical restraint (a new sentinel event category). A critical issue will be how services identify that a consumer has experienced 'serious harm'. However, in responding to complaints to the MHCC, services have highlighted that it does not seem appropriate that a person who is restrained pursuant to a 'duty of care' does not have the same legislative protections and safeguards as a person who is on a compulsory treatment order.

In the past year, the MHCC dealt with a complaint that raised serious allegations of abuse and neglect of residents of an aged persons' mental health residential care facility, including concerns about the use of restrictive practices. The Secretary of the Department of Health and Human Services confirmed that these facilities are subject to the Commonwealth *Aged Care Act 1997* and the provisions in the Act for the use of restrictive interventions do not apply. It is well documented that there is an inadequate framework for the use of restrictive interventions in aged care under Commonwealth law.⁵⁵ This complaint led to a number of recommendations to the Secretary of the Department of Health and Human Services to address the gaps in the current safeguards and oversight for consumers in these facilities, and work being undertaken by the Chief Psychiatrist and Chief Mental Health Nurse to strengthen the oversight and model of care in these facilities (See Appendix B).

4.5 Rights, autonomy and choice in treatment and supports

The use of compulsory treatment places significant restrictions on a person's autonomy and, in the case of compulsory inpatient treatment, liberty. The Act provides that compulsory assessment and treatment may only be used where necessary to prevent serious deterioration in the person's physical or mental health, or serious harm to the person or another person. However, themes in complaints to the MHCC and in our broader education and engagement work indicate that the gravity of compulsory treatment and the restrictions it places on people's human rights are not well understood or routinely considered in mental health services when making decisions about compulsory treatment.

⁵⁵ See for example, Carnell, K and Paterson, R, *Review of National Aged Care Quality Regulatory Processes*, 25 October 2017.

One of the objectives of the Act was to place people at the centre of their treatment of care and enable them to make or participate in decisions about their treatment and care. The Act includes a presumption that people with mental illness, including people who are receiving compulsory treatment, have capacity to make decisions about their treatment. This is perhaps the most significant change from the *Mental Health Act 1986* which included lack of capacity as a criterion for initiating involuntary treatment.

Accordingly, the mental health principles provide that people should be supported to make or participate in decisions about their assessment, treatment and recovery, and that their views and preferences should be respected⁵⁶. The Act establishes several mechanisms to support people to make and participate in treatment decisions, including advance statements, nominated persons and the right to a second psychiatric opinion. Issues arising in each of these areas are outlined later in this section. These are all ways to mitigate the serious restrictions on autonomy and liberty that are inherent in the use of compulsory treatment, and to ensure that people are able to preserve their autonomy as far as possible.

However, themes from complaints to the MHCC, as well as feedback received through our broader education and engagement work, indicate that significant improvements are required in the way services understand and apply human rights principles, and promote autonomy by enabling and supporting people to make decisions about their treatment. In the MHCC's view, multifaceted strategies are required to make these improvements.

One of the changes required is creating a culture of human rights within mental health services, where all staff have access to training, as well as supervision and professional development structures that to help them to deeply understand human rights principles and meaningfully apply these to the provision of care. This work to change culture can only be done with the input and leadership of people with lived experience, who have experienced the impacts of having their human rights limited by the provision of compulsory mental health treatment.

In addition, systems and structures within mental health services must change to be inclusive of consumers, their families and carers and support their involvement in every element of care and treatment. Current examples of structures that do not support involvement include complex care committees, shift handovers, and other clinical meetings where decisions are made *for* consumers without their views being represented (either directly by the consumer, by their family, carer, nominated person or other support person, or by an advocate).

Themes from our education and engagement work indicate that there are also limited opportunities for the peer workforce to engage in these discussions and support consumer involvement in decision making about their treatment and care. The MHCC does note that some services are seeking to change their practices to genuinely involve consumers and their support people more fully in all elements of their care (for example, by jointly completing

⁵⁶ s 11(1)(c) *Mental Health Act 2014* (Vic)

risk assessments or by directly involving consumers in handovers), however in the MHCC's observation this remains the exception rather than the norm.

The following sections provide an overview of issues relating to human rights, autonomy, choice and supported decision making in complaints made to the MHCC.

Consideration of views and preferences

One of the most consistently common themes in complaints to the MHCC is from consumers, families, carers and nominated persons stating that their views about treatment, and consumers' preferences, have not been adequately considered by the service. These issues are often raised in conjunction with other issues about advance statements, second psychiatric opinions, and consent as outlined further in this section. Common examples include:

- consumers' concerns about medication side-effects not being adequately considered or responded to, for example by considering other medications or adjusting doses
- consumers' preference for oral over depot medication not being responded to
- consumers' preferences for community, or private treatment not being adequately considered
- the views of families and carers not being considered as part of treatment planning, particularly in relation to discharge planning.

Capacity and consent

The Act defines capacity to give informed consent to treatment as a person being able to understand, remember, use and weigh information that is relevant to the decision to be made, and to be able to communicate that decision by speech, gestures or any other means⁵⁷. Section 69 of the Act also provides that:

- capacity is specific to the decision to be made
- capacity may change over time
- it should not be assumed that a person does not have the capacity to give informed consent based only on his or her age, appearance, condition or an aspect of his or her behaviour
- a determination that a person does not have capacity to give informed consent should not be made only because the person makes a decision that could be considered to be unwise
- when assessing a person's capacity to give informed consent, reasonable steps should be taken to conduct the assessment at a time at, and in an environment in, which the person's capacity to give informed consent can be assessed most accurately.

To be able to provide informed consent, a person must be given adequate information to make an informed decision, have been given a reasonable opportunity to make the decision, have given consent freely without undue pressure or coercion, and have not withdrawn consent or indicated any intention to withdraw consent.

⁵⁷ s 68 *Mental Health Act 2014* (Vic)

Issues arising in complaints to the MHCC about consent have included:

- communication about assessment and treatment not being clear to consumers
- staff not engaging consumers in discussions about whether they would agree to a voluntary admission, rather than defaulting to compulsory treatment
- staff advising consumers who have been admitted voluntarily to an inpatient unit that if the consumer tries to leave, staff will initiate compulsory treatment. This has the effect that consumers do not have the choice to leave, but also do not have the safeguards and oversights of being a compulsory patient under the Mental Health Act
- consumers not being provided with enough information about the potential side-effects of ECT or given enough time to consider a decision to undertake it
- consumers not being provided with enough information about the medication they are prescribed
- a lack of explanation about the differences between community and inpatient treatment that meant that consumers could not make an informed decision between the two.

Advance statements

The Act also outlines provisions relating to advance statements, where consumers may set out their preferences in relation to their treatment if they become a compulsory patient. A consumer's preferences as set out in their advance statement may be overridden by an authorised psychiatrist if they are not clinically appropriate, or not a treatment ordinarily provided by the mental health service. Issues arising in complaints about advance statements have included:

- staff either involving or not involving consumers' families against their wishes set out in their advance statements
- consumers' concerns that they will be given ECT⁵⁸, depot injections or other medications despite their wishes as set out in their advance statements
- advance statements not being located or considered at all as part of making a treatment decision.

The MHCC often suggests or recommends the completion of an advance statement as part of the resolution of a complaint, to try to ensure that the consumer's views and preferences are central to any future treatment. It is common that consumers have not previously been offered the opportunity or supported to complete an advance statement.

Statement of Rights and Mental Health Tribunal appeals processes

The Act also outlines that a statement of rights should be provided and explained to persons receiving compulsory mental health treatment. A statement of rights gives people information about their rights as a compulsory patient, for example information about the right to apply to the Mental Health Tribunal (MHT) for a revocation of a compulsory treatment order. A statement of rights is one tool among many to ensure that people receiving compulsory treatment are informed about their rights and supported to exercise them. However, complaints to the MHCC show that the provision of information about rights is too often

⁵⁸ Electroconvulsive Treatment

treated as a 'tick-box' exercise rather than being part of an ongoing discussion with patients over time.

Issues arising in complaints about statements of rights and support to contact the MHT have included:

- compulsory patients not being provided with their statement of rights, or the statement was only provided on request
- staff not verbally explaining a statement of rights, including to consumers who had literacy issues
- a statement of rights being provided and discussed once, at a time of high distress, and not revisited at a time when the compulsory patient may have been more able to understand and use the information
- a statement of rights only being provided after a delay
- statement of rights not being provided or explained to the carers of a child
- treating teams not informing compulsory patients about their right to appeal to the MHT, explaining the appeal process or providing the forms required to make an application for revocation of a treatment order.

Second psychiatric opinions

The Act further outlines that compulsory patients⁵⁹ are entitled to seek a second psychiatric opinion at any time, and the authorised psychiatrist must ensure that reasonable steps are taken to assist the patient with that request. The psychiatrist providing a second opinion may make recommendations which, if made, should be reviewed by the authorised psychiatrist. If the authorised psychiatrist decides to adopt only some or none of the recommendations in the second opinion report, he or she must give their reasons and an explanation of those reasons to the patient. There is further provision in the Act for a patient to seek a review from the Chief Psychiatrist in this case. It is worth noting that while the Act does not provide that voluntary patients have a right to a second psychiatric opinion, as a matter of good practice and supporting the autonomy of individuals, the MHCC's view is that these requests should be supported and facilitated wherever possible (for example, if the service is unable to or has previously offered an internal second opinion, supporting the person to identify a bulk-billing private psychiatrist who may be able to provide a second opinion).

Since 2014, the MHCC has received several complaints in relation to the provision of second opinions. Issues arising in these complaints included:

- consumers asking to see a different psychiatrist and being refused
- compulsory patients not being provided with information about the right to a second opinion
- consumers not being able to access to a second opinion
- delay in obtaining second opinions, sometimes due to delays in transferring medical reports.

⁵⁹ The discussion in this section also applies to security patients and forensic patients as defined in sections 3 and 305 of the Act.

Least restrictive treatment

The mental health principles also provide that persons receiving mental health treatment should be provided assessment and treatment in the least restrictive way possible, with voluntary assessment and treatment being preferred which is discussed below in section 4.6.

Right to communicate

The Act provides that compulsory inpatients have a right to communicate lawfully with other people. However, the right to communicate may be restricted if the authorised psychiatrist is satisfied that it is necessary to protect the health, safety and wellbeing of the inpatient or of another person. Restrictions cannot be placed on the right to communicate with legal representatives, the chief psychiatrist, the MHCC, the Mental Health Tribunal or community visitors. Where communication is restricted, steps must be taken to notify the consumer and families or carers of the restriction of communication and the reasons for it, and the decision to restrict communication should be reviewed regularly.

Since its establishment, the MHCC has received several complaints about the right to communicate and restriction of communication, including complaints about restriction of the use of phones or electronic devices, complaints raising issues about restriction in receiving visitors, and complaints relating to restrictions on access to legal aid or statutory bodies.

Issues arising in these complaints included:

- confiscation of phones and electronic devices, resulting in feelings of isolation. This includes examples where mobile phones or devices are removed as a matter of routine in some environments (e.g. ICAs)
- restrictions on the number of phone calls that can be made in one day
- being required to ask staff for permission before calling families/carers
- family members not being allowed to call or visit.

Complaints about restriction of communication have been raised consistently over the last 5 years. The MHCC made a formal recommendation to the Secretary of DHHS in 2014-15 to develop policy and practice guidance on access to mobile phones and other communication devices for consumers during inpatient admissions that is consistent with the right to communicate, recovery-oriented practice, least restrictive practice and the Charter. This recommendation led to the development of the Chief Psychiatrist's Guideline on *Electronic communication and privacy in designated mental health services*, published in 2018. The MHCC notes that we have seen an improvement in practices and responses from mental health services over time, demonstrating the value of having a specialist independent complaints body that is able to make recommendations and influence system change.

Despite the improvements in this area, it is clear from complaints to the MHCC that many people receiving treatment, particularly compulsory inpatient treatment, do not receive sufficient support to exercise their right to make decisions about their mental health treatment. Changing this requires attention both to culture and to the pressures on services, which the MHCC acknowledges are significant and inevitably do have an impact on services' ability to think deeply about rights and consumer autonomy and work closely with consumers, their families, carers and support networks to ensure these rights are upheld. However, further investment in mental health services without adequate attention to

developing a human rights culture in mental health services will simply result in more people receiving treatment that does not place human rights considerations at its core.

4.6 Least restrictive treatment

A key and underlying concern raised in many complaints to the MHCC is that assessment, treatment and care has not been provided in the least restrictive way possible. It is a foundational principle of the Act that consumers are provided 'assessment and treatment in the least restrictive way possible'⁶⁰ and one of criteria for making compulsory treatment orders that 'there is no less restrictive means reasonably available to enable the person' to be assessed⁶¹ or to receive immediate treatment⁶². Consumers commonly express the negative and traumatic impacts of restrictive and coercive treatments on their mental health and preparedness to seek assistance in the future. It is therefore included as a critical factor to address for people to be able to experience good mental health outcomes through treatment provided by mental health services.

As outlined in section 4.4 above, the MHCC deals with a range of complaints which raise significant issues about the failure to adequately consider less restrictive options before restrictive interventions are used. Another situation raised in complaints to the MHCC is where a consumer believes that less restrictive options were not adequately explored before the person was placed on an Assessment Order under the Act.

Issues identified in complaints about Assessment Orders include complaints where:

- inadequate consideration of alternative treatment options through private providers, for example in one complaint where a consumer requested that the service facilitate her admission to a private psychiatric facility, and there was no discussion by clinicians with her private psychiatrist, general practitioner, or the private facility before she was placed on an Assessment Order.
- failure to consult with a person's family members before placing a person on an Assessment Order even when the family member is present; for example, in one complaint where a woman presented to the emergency department voluntarily and was assessed by staff as agitated when she spoke in another language, and when staff did not speak to her relatives who were present before making an Assessment Order
- lack of clarity about the risk to the person or others before being placed on an Assessment Order, for example in a complaint where the person was placed on an Assessment Order to assess his physical health and whose order was revoked the next day.

In each of these cases the person was detained overnight and then their Assessment Order was revoked the next day following a review by the authorised psychiatrist.

⁶⁰ s 11(1)(a) *Mental Health Act 2014* (Vic)

⁶¹ s 29(d) *Mental Health Act 2014* (Vic)

⁶² s 5(d) *Mental Health Act 2014* (Vic)

Assessment Orders are not subject to any independent review or monitoring as to whether the criteria to make an order and detain a person has been met. The MHCC's assessment and investigation of recent complaints has indicated that there can be a complacency and desensitisation of some staff about the impact of detaining a person in a service that is inconsistent with the person's human rights and is contrary to the mental health principles, including the requirement to provide assessment and treatment in the least restrictive way possible.

Other issues identified in complaints about treatment not being provided in the least restrictive way possible, and which point to the need for systemic change and improvement include:

- consumers being treated as inpatients, which in some instances people felt was too restrictive and they would have preferred community-based treatment
- consumers being treated in an intensive care area (ICA) when they preferred to be treated in the general unit. The MHCC has observed, including in the *Right to be safe* report, that services often perceive admission to an ICA as a protective safety measure. However, consumers commonly report to the MHCC that they feel less safe in an ICA environment. This is supported by the findings of the *Right to be Safe* report which indicated that a high proportion of sexual safety breaches occurred in ICAs and that this environment may be particularly inappropriate for women with a history of sexual trauma.
- people being placed on Assessment or Treatment Orders when they would have agreed to voluntary treatment, or had other community alternatives that were not sufficiently explored as a less restrictive option (for example, an admission to a private mental health service)
- families and carers not being included in conversations about less restrictive treatment options, including treatment from private practitioners and services
- consumers being given medication by injection rather than orally, including concerns about over-medication.

4.7 Trauma informed care

Trauma-informed care is foundational to providing quality, safe mental health services. Where people experience care that is not trauma-informed, this makes it difficult for them to achieve and maintain good mental health.

Trauma prevalence

The prevalence of trauma among people accessing public mental health services is widely acknowledged, with:

- between 49 and 90 per cent of women accessing inpatient mental health treatment having experienced abuse (sexual and/or family violence) at some stage in their lives.
- prevalence rates for interpersonal violence being twice as high for men with a mental illness compared with the general population, with one study showing that 40 per cent of men in an inpatient unit had experienced childhood sexual abuse.
- the types of trauma experienced by those accessing mental health services tending to be interpersonal in nature, intentional, often prolonged and repeated, occurring in

childhood and adolescence as well as in adult life, and extending across many years or over a person's life. They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional or psychological abuse. They may also include the witnessing of violence, repeated abandonment, and sudden and traumatic losses⁶³.

Particular demographic groups are also more likely to have experienced trauma. Australia's history of colonisation and the loss of family, language, land, spirituality and culture for Aboriginal people, as well as past practices including forced removal of children, mean that Aboriginal communities have experienced multigenerational trauma that continues to have significant impacts⁶⁴. Other groups with extremely high prevalence of trauma include people from refugee backgrounds and people who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI). There is evidence worldwide that women with serious mental illness are far more likely than the general population to experience sexual violence⁶⁵. In addition, women with intellectual disability have been estimated to be 10 times more likely than other women to be sexually assaulted⁶⁶.

Given the high prevalence of trauma among people accessing mental health services, implementing trauma-sensitive and trauma-informed care must be a high priority for mental health services.

Trauma-informed services

Trauma-informed services recognise the prevalence of trauma in general society and are organised to avoid further harm to already traumatised people, acknowledging that complex trauma may not be identified or known by the service. Specifically in mental health services, trauma-informed services would:

- recognise the harms associated with the spectrum of coercive and restrictive practices permitted by mental health law and endeavour to eliminate their use
- employ the lived experience workforce on a scale that achieves a critical mass and build on existing peer led and delivered initiatives to ensure consumers have access to peer support

⁶³ Department of Health 2011a, Service guideline on gender sensitivity and safety, Victorian Government, Melbourne.

⁶⁴ The Bouverie Centre 2013, *Guidelines for trauma-informed family sensitive practice in adult health services*, The Bouverie Centre, Brunswick.

⁶⁵ Basile KC, Smith SG, Fowler DN, Walters ML, Hamburger ME 2016, 'Sexual violence victimization and associations with health in a community sample of African American women', *Journal of Aggression, Maltreatment and Trauma*, vol. 25, no. 3, pp. 231–253; Goodman LA, Salyers MP, Mueser KT, Rosenberg SD, Swartz M, Essock SM, Osher FC, Butterfield MI, Swanson J 2001, 'Recent victimization in women and men with severe mental illness: prevalence and correlates', *Journal of Traumatic Stress*, vol. 14, no. 4, pp. 615–632; Khalifeh H, Moran P, Borschmann R, Dean K, Hart C, Hogg J, Osborn D, Johnson S, Howard L 2015, 'Domestic and sexual violence against patients with severe mental illness', *Psychological Medicine*, vol. 45, no. 4, pp. 875–886; Latalova K, Kamaradova D, Prasko J 2014, 'Violent victimization of adult patients with severe mental illness: a systematic review', *Neuropsychiatric Disease and Treatment*, vol. 10, pp. 1925–1939; Mcfarlane A, Schrader G, Bookless C, Browne D 2006, 'Prevalence of victimization, posttraumatic stress disorder and violent behaviour in the seriously mentally ill', *Australian and New Zealand Journal of Psychiatry*, vol. 40, pp. 1010–1011; Seeman MV 2002, 'Single-sex psychiatric services to protect women', *Medscape Women's Health*, vol. 7, no. 4, p. 4.

⁶⁶ Frohmader C 2002, *There is no justice – there's just us: the status of women with disabilities in Australia*, Women with Disabilities, Canberra.

- prioritise people's opportunity to have choice and control in their treatment through ensuring access to supported decision-making mechanisms including advance statements, nominated persons, and access to advocacy services to support people to make real choices about their treatment. It is recognised that sometimes the range of treatments able to be offered within the public mental health system is limited by available resources (e.g. access to talking therapies) and expanded access to these kinds of options is necessary for people to have meaningful treatment options available.

The MHCC notes that in our broader education and engagement work, consumers, families and carers have raised concerns that the meaning of trauma-informed care can be interpreted differently by different people, and that trauma-informed care can be taken to mean 'whatever the service is already doing' rather a re-envisioning of how services operate and how they support compassionate interactions with consumers, families and carers. Consumers, families and carers have noted the significant challenge for services attempting to provide trauma informed care while in many cases using coercive approaches that cause trauma (including compulsory treatment and the use of restrictive interventions). People have also noted the lack of trauma-specific services within inpatient settings and the reluctance of services to consider the impact of trauma on a person's mental wellbeing, rather seeing trauma as something to be addressed elsewhere or after an inpatient admission.

The *Right to be Safe* report sets out some of the principles of trauma-informed care and considers how these apply to ensuring sexual safety in acute mental health units (see Appendix E), which demonstrates one approach to how services can adapt practice to ensure they are trauma-informed.

Complaints to the MHCC suggest that despite attempts at implementing trauma-informed care within Victorian public mental health services, many people do not experience a system that is trauma informed.

Approaches to implementing trauma-informed care

There are few examples of trauma-informed care being successfully implemented in a mental health inpatient environment⁶⁷. Existing research on implementing trauma-informed care generally tends to focus on reducing rates of restrictive interventions. There is some evidence that models of change that are based in trauma-informed principles and use strategies including leadership, use of data, skill development and involvement of people with lived experience can have a positive effect on reducing seclusion and restraint⁶⁸, and these models may have broader applicability for the implementation of trauma-informed care.

⁶⁷ Muskett C 2014, 'Trauma-informed care in inpatient mental health settings: a review of the literature', *International Journal of Mental Health Nursing*, vol. 23, no. 1, pp. 51–59.

⁶⁸ Azeem MW, Aujla A, Rammerth M, Binsfeld G, Jones RB 2011, 'Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital', *Journal of Child and Adolescent Psychiatric Nursing*, vol. 24, no. 1, pp. 11–15.

Safewards

The implementation of the Safewards program in Victoria may also provide a model that could be adapted or expanded to support services to move closer to a model of trauma-informed care. Safewards is an approach that uses a range of strategies that focus on ways to promote more positive interactions between staff and people using services, as well as establishing a regular ‘mutual help’ meeting with staff and people accessing inpatient treatment. Safewards encourages staff to take a strengths-based perspective regarding consumer behaviour; that is, assuming the person is coping as best as they can under the circumstances, recognising trauma-related responses and applying psychological understandings compared with merely challenging behaviour. Safewards has been evaluated in the UK and in Victoria. In both jurisdictions, it was found that implementing the Safewards interventions led to a reduction in ‘conflict and containment’ practices⁶⁹ (including seclusion and restraint).

Practice considerations

Some of the key practice/skill and competency challenges to implementing trauma-informed care are discussed below, including embedding supported decision making in mental health service practice and expanding the availability of peer support approaches.

Supported decision making

Supported decision making is fundamental to implementing trauma-informed care. As experiences of trauma are often characterised by a lack of control and disempowerment, supporting people to exercise autonomy and make choices is a critical trauma-informed care strategy.

The principles of the Act require that people have access to the supports they need to make treatment and recovery decisions (s 11 (1)(c)). The Act also contains provisions for advance statements, nominated persons and access to a second psychiatric opinion as means of people maintaining autonomy and agency. The establishment of the Independent Mental Health Advocacy (IMHA) service provides an additional way to support people to access independent support to make treatment and recovery decisions.

Advance statements are a way for people to express their views and preferences about their treatment, should they become unwell and receive compulsory treatment in the future. They may be particularly useful in avoiding re-traumatisation for people with a history of trauma, by providing a way for the person to have input into and choice of treatment options, even while experiencing an acute episode of illness. Advance statements could be used to provide an overview of triggers for trauma, suggest preferred support strategies or approaches, and provide advice about what would help the person to feel safe if an admission is required. Given that the initiation of compulsory treatment imposes significant restrictions on people’s rights and autonomy, this should be a particular prompt to ensure the person has access to

⁶⁹ Bowers L, James K, Quirk A, Simpson A, Stewart D, Hodsoll J 2015, ‘Reducing conflict and containment rates on acute psychiatric wards: the Safewards cluster randomised controlled trial’, *International Journal of Nursing Studies*, vol. 52, pp. 1412–1422; Fletcher, J, Spittal M, Brophy L, Tibble H Kinner S, Elsom S, Hamilton B 2017, ‘Outcomes of the Victorian Safewards trial in 13 wards: impact on seclusion rates and fidelity measurement’, *International Journal of Mental Health Nursing*, no. 26, pp. 461–471.

supported decision-making mechanisms. However, complaints to the MHCC indicate that even when a person has experienced a traumatic event during inpatient treatment, developing an advance statement to ensure the person's views and preferences are known and respected in treatment planning for any future inpatient admission is rarely considered.

Therapeutic engagement

Transparent and supportive therapeutic relationships between staff and consumers are also key to better implementing supported decision making⁷⁰, and, by inference, to implementing trauma-informed care. Consumers have stressed the need for service staff to be genuine and empathetic in their interactions⁷¹ and positive relationships with staff has been identified as the most important factor in an effective mental health inpatient stay⁷² However, both staff and people with experience of inpatient treatment expressed concerns in consultations for the MHCC's sexual safety project and in broader complaint work about the limited time that is available or taken by staff to engage therapeutically with people accessing treatment, within the constraints currently faced by mental health services.

Access to peer support

Increased access to peer support may also help to ensure people can access trauma-informed services. For example, during consultations for the MHCC's sexual safety project, consumers reported that they may feel more comfortable raising concerns about sexual safety with a peer worker rather than a nurse. Others noted the significant impact of the support that people offer each other during inpatient admissions to help each other to be and to feel safe; this is also supported by literature⁷³. The value of increasing access to peer support is also supported by the Victorian Safewards evaluation, which found that consumer consultants viewed mutual help meetings in particular as an extremely positive intervention, suggesting that 'intentionally increasing mutual support could reduce anxiety and fear on the ward'⁷⁴.

International approaches to implementing trauma-informed care

Approaches used in other jurisdictions may be useful for Victoria to consider in attempting to implement trauma-informed care. For example, the National Health Service's Education for Scotland *Transforming psychological trauma: a knowledge and skills framework for the*

⁷⁰ Healthtalk Australia 2016, *Fact sheet 3: practices to improve supported decision making in mental health service*, Healthtalk Australia, Melbourne

⁷¹ Gilbert H, Rose D, Slade M 2008, 'The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK', *BMC Health Services Research*, no. 8, pp. 92–104; Gunasekara I, Pentland T, Rodgers T, Patterson S 2014, 'What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service user', *International Journal of Mental Health Nursing*, vol. 23, no. 2, pp. 101–109; Sweeney A, Fahmy S, Nolan F, Morant N, Fox Z, Lloyd-Evans B, Osborn D, Burgess E, Gilbert H, McCabe R, Slade M, Johnson S 2014, 'The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: a cross-sectional study', *PLoS One*, vol. 10, no. 9(7):e100153.

⁷² Wood L, Alsawy S 2016, 'Patient experiences of psychiatric inpatient care: a systematic review of qualitative evidence', *Journal of Psychiatric Intensive Care*, vol. 12, no. 1, pp. 35–43.

⁷³ Rebeiro Gruhl KL, LaCarte S, Calixte S 2016, 'Authentic peer support work: challenges and opportunities for an evolving occupation', *Journal of Mental Health*, vol. 25, no. 1, pp. 78–86

⁷⁴ Hamilton, B, Fletcher, J, Sands N, Roper C, Elsom S 2016, *Safewards Victorian trial final evaluation report*, Centre for Psychiatric Nursing, Melbourne, p. 44.

*Scottish workforce*⁷⁵ provides an alternative framing of trauma-informed approaches to service delivery. This framework emphasises that all elements of the workforce have a role to play in ensuring that services are safe and provide the maximum opportunities to identify and respond to trauma. An outline of the framework is provided in Appendix F.

4.8 Sexual safety in acute mental health inpatient units

Over the MHCC's first two years of operation, the MHCC 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. Given significant risks to people's sexual safety in acute mental health inpatient units, and the devastating consequences of sexual assaults and other breaches of people's sexual safety, the MHCC has identified sexual safety as a priority issue to address.

In 2018, the MHCC completed a major project, the sexual safety project, which included four major investigations, analysis of complaints about sexual safety made to the MHCC and reported in services' biannual complaints reports to the MHCC, consultations with key stakeholders and an extensive literature review.

This project resulted in *The Right to be Safe* report⁷⁶ which is referenced throughout this submission. The full report is available on the MHCC's [website](#), and a summary of the approach taken in this report, its findings and recommendations and further steps taken to follow up these recommendations is detailed in this section of the submission.

Background to sexual safety project and report

The Act requires services to be provided in a way that upholds people's dignity and rights, promotes therapeutic outcomes and supports people in their recovery. People accessing acute mental health inpatient treatment are acutely unwell and may also be in these environments compulsorily. They may be particularly vulnerable to the behaviours of others in a closed environment or at risk of behaving in ways or making decisions that they would not otherwise if they were well. Ensuring people's safety, including sexual safety, in acute mental health inpatient units is a fundamental prerequisite to achieving the objectives and meeting the mental health principles of the Act and upholding people's human rights.

Reviews, surveys and advocacy reports over many years consistently identified that many people do not feel, or are not, sexually safe when accessing acute mental health inpatient treatment. Themes highlighted include people not feeling safe, or experiencing sexual harassment and alleged sexual assault. Similar themes were noted in complaints to the MHCC over the first two years of operation, and were the impetus for the sexual safety project.

⁷⁵ NHS Education for Scotland 2017, *Transforming psychological trauma: knowledge and skills framework for the Scottish workforce*, Scottish Government, Edinburgh.

⁷⁶ Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018

Sexual safety was defined in the sexual safety project to include '**feeling and being sexually safe in these environments, including being free from sexual activity, sexual harassment and alleged sexual assault**'. Significantly, breaches of sexual safety are rarely experienced by people accessing general health services and must be treated as unacceptable in any environment.

The sexual safety project focused on acute mental health inpatient units because of the higher risk of sexual safety breaches occurring between people accessing inpatient treatment, and because people may be so unwell when in these settings that it is not possible to accurately gauge whether a person is able to consent to sexual activity. This is demonstrated in some complaints to the MHCC, where sexual activity was initially assessed by the service as consensual. However, the consumer or consumers involved later expressed a belief that they had been too unwell to be able to consent to sexual activity and that the service had failed in their duty to ensure their safety while receiving inpatient treatment. There is compelling evidence on the serious, and long-lasting consequences that can arise from unwanted sexual activity, or even from witnessing sexual activity while an acutely unwell inpatient, which supports the position in the current Chief Psychiatrist guideline that '*any sexual activity in an adult acute inpatient unit is incompatible with the acute treatment environment and is unacceptable.*'⁷⁷

In longer term mental health settings, the level of risk and the considerations as to whether sexual activity is appropriate are different and include striking an appropriate balance between ensuring safety, promoting sexual health and wellbeing and enabling people to live a full and meaningful life, which includes the ability to form relationships. Though outside the scope of the sexual safety project, consultations identified the need for services to be provided with guidance on ensuring sexual safety in these settings. Reports of breaches of sexual safety in longer term care environments must always receive a similarly rigorous response from mental health services.

The sexual safety project and report focused on key themes and issues identified through analysing complaints about sexual safety in acute inpatient environments, in particular sexual safety breaches involving other people accessing treatment (76 per cent of complaints). This is not to understate the seriousness of complaints about staff. Rather, this recognises that the steps required to respond to complaints about staff are clearer and acknowledges that there are existing regulatory and legal mechanisms for addressing allegations against staff. In contrast, responses to sexual safety breaches by other people accessing services were highly variable in the complaints reviewed, and, in many cases, concerning.

Because of the variability in reporting and categorising incidents relating to sexual safety, it is not possible to gain a clear picture of the prevalence of sexual safety breaches or whether these have increased or decreased over time. Incident reporting was addressed in the

⁷⁷ Department of Health 2009, *Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in acute inpatient units: Chief Psychiatrist's Guideline* (updated June 2012), Victorian Government, Melbourne, p1

recommendations of this report, with a view to understanding the true prevalence and nature of these breaches and better informing prevention strategies. The MHCC notes the implementation of specific reporting of sexual safety breaches to the Chief Psychiatrist. However, we know from complaints made to our office since the implementation of this process that not all sexual safety breaches have been reported to the Chief Psychiatrist in a timely way, and there have been instances where reports have either been unreasonably delayed or only made once a complaint has already been made to the MHCC. It is also possible that further numbers of sexual safety breaches have not been reported, about which neither the Chief Psychiatrist nor the MHCC has been informed. This points to the need to continue to explore options for improved reporting and oversight mechanisms, including through modifications to the Victorian Health Information Management System⁷⁸.

Project findings

The project highlighted several key patterns in complaints made to the MHCC and to services:

- most complaints about sexual safety relate to men breaching the sexual safety of women.
- Intensive care areas (ICA) were identified as high-risk areas for sexual safety breaches.
- Over three-quarters of complaints identified other people accessing services as alleged perpetrators. It is important to note that, in a context where all people accessing services are acutely unwell, services have a duty to both parties to prevent both the harm associated with any breach of sexual safety and the potential ramifications for a person identified as perpetrating any breach of sexual safety. It is also important to note that complaints about staff actions may be under-reported, for example because people may believe they will not be taken seriously including that staff accounts of what occurred would be believed over the account of a consumer.
- Complaints made to the MHCC and mental health services were most commonly about alleged sexual assault, followed by broader concerns about gender safety.

The findings of this project, and of further complaints to the MHCC since the project's completion, indicate that it is difficult for mental health services and staff to prevent all sexual safety breaches in a mixed-gender acute inpatient environment, particularly in ICAs. Staff, no matter how diligent, cannot constantly observe all people accessing treatment. The need to continuously monitor and intervene to ensure people's sexual safety in these environments may also detract from the capacity of staff to engage therapeutically with people accessing treatment.

In addition, for some people (for example, people with a history of sexual trauma or people from particular cultural or religious backgrounds), providing mixed-gender acute inpatient treatment may present inherent challenges to feeling safe. For this reason, one recommendation of the project was to trial single-gender acute inpatient units, with an initial

⁷⁸ See discussion in section 2.5.6 'Reporting of incidents' in the Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018, pp99-103

focus on women-only units. The MHCC also recommended that all inpatient units have areas that can be used flexibly to accommodate individual needs, including the needs and preferences of LGBTIQ+ consumers. While the implementation of single-gender units would not of itself prevent all sexual safety breaches, the data from complaints made to the MHCC and relevant literature, indicates that single-gender units would dramatically reduce the frequency and gravity of the nature of any breaches.

Recommendations

The overarching recommendation of the project was for the Department of Health and Human Services to develop a comprehensive sexual safety strategy that plans, coordinates and monitors action to prevent and respond to breaches of sexual safety in Victorian acute mental health inpatient units. The MHCC recommended that this strategy draws together and expands on existing approaches and be underpinned by a clear policy directive for mental health services on requirements and actions to ensure sexual safety. The MHCC also recommended that this reflect the principles of:

- human rights – applying the principles and objectives of the Mental Health Act, the Charter and relevant standards
- violence prevention – applying the principles of primary, secondary and tertiary prevention
- trauma-informed care and supported decision making – recognising the prevalence of trauma among people accessing acute mental health inpatient treatment, and developing systems that respond to likely trauma in assessment, treatment and recovery planning and actively seek to avoid re-traumatisation
- recognising and responding to diversity – understanding the diversity of needs and the particular risks and challenges that are associated with a person’s gender, sexuality, culture, disability, age and background
- working with people with lived experience and peer support to develop approaches for supporting people to feel and be safe while accessing acute mental health inpatient treatment.

The project also made recommendations for practice and service improvements including:

- addressing **governance** issues by establishing clear reporting and monitoring mechanisms to better identify and respond to sexual safety breaches, and ensure accountability for their prevention
- ensuring **leadership** supports best practice in preventing and responding to breaches of sexual safety
- implementing **trauma-informed care** as a primary prevention strategy, in recognition of the prevalence of trauma among people accessing acute inpatient mental health treatment and the re-traumatising impacts of sexual safety breaches
- developing plans for minimum **infrastructure** requirements to support sexual safety in mixed-gender environments and piloting and evaluating single-gender units
- developing a plan to improve the safety of **ICAs** and developing alternative strategies for supporting people who are particularly at risk in these environments
- ensuring **orientation** to the inpatient unit clearly outlines that sexual activity is not permitted in the inpatient unit

- ensuring **risk assessment** assesses vulnerability and perpetrator risks as well as the overall environment of the inpatient unit, and clearly links to plans for managing identified risk
- developing 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 that staff are supported in conducting open disclosure
- developing clear guidance on the duty of services to **report** a suspected or alleged sexual assault to Victoria Police, consistent with guidance in other service settings
- developing clear 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
- providing clear guidance to mental health services in relation to **investigating** and reporting sexual safety breaches that ensures people accessing services receive responses that are consistent with those in other service settings
- ensuring **incident reporting** mechanisms and requirements are integrated and consistent with standards in other service settings, and allow for patterns in reported incidents to be identified for quality improvement
- ensuring observations and reports are clearly and accurately **documented** at the time of the sexual safety breach
- ensuring **discharge planning** clearly identifies the nature of any breach experienced, as well as planning for future admissions and an outline of necessary support and referral for the person, their family and/or carers.

Details of the separate recommendations made under each of the above areas to the Secretary of the Department of Health and Human Services, to the Chief Psychiatrist and to mental health services under section 228(j) of the Act are included at Appendix C to this report. We have sought information from mental health services about their responses to the recommendations of *The Right to be Safe*. We discuss these responses in our regular meetings with services and use this information when assessing and resolving complaints. From these responses, meetings and complaints, the MHCC is aware that some relatively simple actions that could be taken to better ensure safety are still not in place. For example, the MHCC still receives complaints that:

- people are unable to lock their bedroom doors
- single-gender corridors are not locked or enforced
- single-gender corridors must be traversed for consumers to reach communal areas, rendering the corridor completely ineffective in creating a sense of safety for women who may feel afraid or traumatised by the presence of male consumers in the inpatient unit.

The MHCC continues to work with DHHS, the Office of the Chief Psychiatrist and mental health services to progress the report's recommendations and ensure the sexual safety of people accessing mental health services. However, despite significant improvements in the approach of some services to preventing and responding to sexual safety breaches, we note that people continue to make complaints about experiencing sexual harassment or alleged assault, or other sexual safety breaches to our office, indicating that there is still significant work to do to ensure people's safety.

4.9 Quality and safety and avoidable harms

As noted elsewhere in this submission, complaints to the MHCC include serious concerns about significant avoidable harms that people have experienced within the mental health service system. This includes complaints about significant avoidable harms experienced within mental health services, including adverse outcomes associated with the use of restrictive interventions (restraint and seclusion) as well as allegations of physical and sexual assault. These harms have significant impacts and costs, primarily for the person who had the negative experience, for whom the impact can be life-long. Where people have experienced significant fear and trauma while in an acute inpatient environment, this has with lasting impacts for the person and can lead to people avoiding any future contact with mental health services.

It is important to note that these experiences of fear and trauma can relate to being physically or sexually assaulted or subject to restrictive interventions but can also relate to feelings created simply by being treated in a system where these things occur. Consultations have also indicated that the use of restrictive interventions and other forms of coercion including compulsory treatment, can create a self-fulfilling prophecy of sorts. Consumers describe feeling unsafe due to the use of these interventions, and these feelings of being unsafe have significant impacts on their ability to engage with the treating team. Communication difficulties can then lead to the likelihood of further coercion or restriction of rights. This all points to the need to continue to invest in strategies to eliminate the use of restrictive interventions and to ensure people's physical and sexual safety within mental health services.

Assessments and investigations of complaints to the MHCC have identified failures in leadership and governance that have led to inadequate oversight of critical incidents and poor responses to adverse events, along with failures to uphold the rights, principles and requirements set out in the Act. The role of leadership and adequate governance structures and systems is therefore an important consideration if lasting change is to be achieved. As part of this consideration, it is also important for the Royal Commission to consider the adequacy of existing safeguarding, regulatory and legislative frameworks to protect people's rights and support the desired reforms to the system.

We refer also to the *Targeting Zero* report that demonstrated the need for effective oversight of quality and safety in health care settings to eliminate avoidable harm and strengthen quality of care.⁷⁹ The report noted the additional risks '*that are uniquely or strongly associated with mental health settings*', including '*self-harm and suicide, assault (including sexual violence) from other patients....along with trauma or physical harm arising from seclusion and restraint*'⁸⁰, and other ways in which adverse outcomes are '*much more common for patients with mental health diagnoses than other patients*'.⁸¹

⁷⁹ Department of Health and Human Services, *Targeting zero: supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care* 2016

⁸⁰ Ibid p133

⁸¹ Ibid p134

The report acknowledged the role of complaints as part of an effective oversight framework and made recommendations to improve the flow of information and data sharing between regulating agencies in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement.

4.10 Physical health, disability and alcohol and other drugs needs

The mental health principles of the Act prescribe that people should have their medical and other health and disability needs recognised and responded to by mental health services. Having these needs met is clearly critical for people's mental health, wellbeing and recovery. When these mental health principles are not upheld by services, this also raises questions about potential discrimination and incompatibility with the Charter.

Complaints to the MHCC have highlighted serious issues about people's physical health conditions, injuries or support for disabilities not being met while being treated on inpatient units. Since 2014, the MHCC has received complaints where consumers say that services have failed to meet their needs in relation to physical health issues or disabilities, including access to mobility aides and medical devices. A key theme in recent complaints to the MHCC has been the failure of services to provide diagnosis, treatment (including the use of medical devices) or medication for physical conditions.

Specific issues identified in complaints about physical health and disability needs not being met include:

- failures to treat urinary tract or bladder infections, to diagnose or treat spinal or other musculoskeletal conditions, to monitor heart conditions, to monitor and treat low iron and potassium levels, to address dental concerns, to treat cold and flu symptoms
- lack of access to pain medication in relation to the above conditions, as well as for more complex pain disorders, such as fibromyalgia and lupus.
- lack of staff knowledge or other difficulties with using CPAP/BIPAP devices for sleep apnoea
- concerns about the adequacy of medical treatment and staff skills in the treatment of the physical health needs of people accessing treatment for eating disorders such as the use of nasogastric tubing
- lack of mobility devices for consumers with pre-existing injuries and disabilities, such as shoulder straps, shower chairs, walkers and suitable wheelchairs
- lack of timely medical review, failure to refer, delays in referral or access to diagnostic test results, and lack of continuity of care
- failures to consider interactions between pain medication and psychiatric medications
- delays in or inadequate treatment for physical injuries sustained during admission to or while on mental health inpatient units, including injuries sustained through the use of mechanical and physical restraint and by assaults by other patients, other injuries sustained on inpatient units, or injuries sustained during the circumstances that led to the consumer's admission
- failures to take into account the specific health needs of female consumers including effects of psychiatric medication on potential pregnancies, and ensuring access to lactation supports and pregnancy/STI tests.

The MHCC has also received multiple complaints in relation to accessibility of mental health services for consumers with dual diagnosis of mental illness and substance abuse/addiction, or where the consumer or their family felt like they had been discriminated against by services for the consumer's use of substances. In these complaints, consumers were either denied assessment or admission to an inpatient unit or were discharged without follow-up from services on the grounds that the primary issue was substance abuse, despite some of these consumers presenting with severe suicidal ideation.

Concerns raised through the MHCC's broader education and engagement work have included the significant impacts on consumers' health and wellbeing when dietetic and exercise interventions are not provided in mental health care settings. Given that many psychotropic medications are known to significantly increase appetite, it is alarming that many people report not receiving interventions to recognise and respond to this, from either inpatient or community-based services. Equally as concerning is the reported lack of health promotion and intervention supporting exercise and its mental health benefits. The long-term effects from failure to intervene in these areas has substantial impact on the quality of mental health consumers' lives.

While the MHCC has addressed specific complaint issues through remedial actions taken by services and recommendations for service improvements, it is evident that action needs to be taken on a systemic level through for instance, specific attention to these issues in the implementation of the 'Equally well in Victoria' framework in mental health services.

4.11 Holistic, inclusive and recovery-oriented treatment

Recovery-oriented practice is, or should be, one of the cornerstones of Victoria's mental health system. Recovery is a consumer-developed concept about how people can build and maintain a (self-defined and self-determined) meaningful and satisfying life and personal identity, regardless of whether there are ongoing symptoms of mental illness.⁸²

In the MHCC's education and engagement work, themes have been expressed that recovery has been 'professionalised to be out of the reach of consumers'; that is, the way recovery is currently conceptualised within mental health services is not meaningful to many consumers.

Personal recovery is a separate concept to clinical recovery and involves a holistic approach to wellbeing that builds on individual strengths.⁸³ Simply put, people cannot experience good mental health if their treatment is not self-determined, inclusive, recovery-oriented and does not address their holistic needs. Recovery involves, among other things:

- having the chance to engage in meaningful activities (which may involve paid or unpaid work, hobbies, and connections to the community)
- having a safe home and environment (noting that many people with mental health challenges have precarious housing situations, feel unsafe in public housing, or

⁸² Shepherd G, Boardman J, Slade M 2008, *Making recovery a reality*, Sainsbury Centre for Mental Health, London

⁸³ Davidson L 2008, *Recovery: concepts and application*, Recovery Devon Group, UK

report a lack of safety or support in environments such as supported residential services)

- being free from stigma and discrimination
- having meaningful connections with family, friends, and the broader community – feeling like a valued citizen
- having spiritual, psychological, emotional, physical and practical needs met
- fostering natural support networks like families and friends, or if these networks do not exist, services working with the person to facilitate access to other supports

However, complaints to the MHCC and feedback from the MHCC's broader education and engagement work indicate that many people experience treatment that is not recovery-oriented, does not support them to make decisions about their own treatment and what is important and meaningful to them, and does not respond to their holistic needs. Details of these kinds of experiences are outlined in other sections of this submission, including:

- *Autonomy, choice and supported decision making (section 4.5):*
- *Least restrictive treatment (section 4.6)*
- *Restrictive interventions (section 4.4)*
- *Trauma-informed care (section 4.7)*
- *Sexual safety (section 4.8)*
- *Physical health, disability and alcohol and drug needs (section 4.10)*
- *Access (sections 4.2 and 4.3)*
- *Service linkages and pathways (section 4.12)*
- *Working with families and carers (section 6)*
- *Responding to the needs of individuals and communities (section 5)*

4.12 Service linkages and pathways

Many complaints to the MHCC raise issues about the inter-relationship between the various components of the mental health system, and their interface with other services and agencies.

Issues raised in complaints to the MHCC include:

- lack of continuity of care when a consumer is discharged from an inpatient unit to the community team of the mental health service
- issues arising when a person is discharged from an emergency department in terms of follow up care and appropriate referrals (see above)
- inadequacy of shared care arrangements and referrals to private practitioners (see further below)
- the experience of some consumers that they cannot access mental health services due to a drug and alcohol dependency, and they are refused access to drug and alcohol services until they receive treatment for a mental illness
- inadequate service responses when consumers have complex needs requiring the collaboration of multiple agencies, such as where a consumer has a dual disability
- inadequate communication and collaboration between mental health services and Victoria Police, for example in one complaint where police were not aware of the

urgency of a police response requested by mental health services, and where an earlier response may have averted the consumer's serious self-harm.

One key issue discussed in other parts of this submission relates to the continuity of care between public and private clinicians. The MHCC has considered a number of complaints where the inadequacy of shared care arrangements with general practitioners (GP) has been a key factor in a significant adverse event for the consumer. In one case a mental health service was not aware that a consumer on a Community Treatment Order had not received his depot injection from a GP for some months prior to his suicide. In another case the public mental health service and the consumer's GP were not clear as to which clinicians were primarily responsible for prescribing medication to the consumer, and her mental health deteriorated significantly leading up to a significant and irreversible incident of self-harm. Another complaint to the MHCC identified that a consumer had been discharged from the community team of a mental health service to a GP when there was no clinical handover, which occurred shortly before the consumer's suicide. The MHCC has made recommendations to the Secretary and Chief Psychiatrist relating to shared care and discharge to external service providers (see Appendix B, items 8 and 11).

A further significant issue arising from several complaints is the barriers to appropriate treatment and care for consumers with multiple and complex needs requiring collaboration by multiple agencies, especially for high risk consumers. This is highlighted by a complaint from a consumer with a dual disability and complex needs who experienced lengthy periods of seclusion in a mental health service, and when all services involved in his treatment and care agreed the facility in which he was detained was unsuitable for him. Although he was entitled to an NDIS funded package the MHCC identified that a key barrier to his discharge from the facility was that there was no agency with overall responsibility for co-ordination, escalation and oversight of his care planning. The MHCC recently made a recommendation to the Secretary arising from this complaint (see Appendix B, item 17).

5. What are some of the drivers behind some communities experiencing poorer health outcomes and what needs to be done to address this (Q 5)

As noted in other sections, accessibility and a lack of cultural safety and appropriateness of services for various communities (including Aboriginal Victorians, culturally and linguistically diverse, refugee and migrant communities, LGBTI Victorians, people with disabilities, people with alcohol and other drug problems, older and younger people) may mean that people either do not seek services, are not able to access appropriate services, or have negative experiences in services that result in poorer mental health outcomes and/or reluctance to access these services in future.

There are also a range of broader issues that affect the mental health outcomes of particular communities – including for example poverty, lack of educational or employment opportunities, lack of safe and secure housing, family violence or experiences of sexual assault or violence. Many of these issues, while critical to address to improve mental health outcomes, are outside the scope of the MHCC's knowledge and expertise. However, mental

health services' responses to these issues can directly affect the health and mental health outcomes of consumers and their experiences of services.

Aboriginal and Torres Strait Islander people

As noted in the Department of Health's *Service guideline on gender sensitivity and safety* and referenced in the MHCC's *Right to be Safe* report:

Aboriginal people conceptualise mental health as social, spiritual and emotional wellbeing; not only relating to the individual person but to the whole community. A holistic approach to care that fosters connection to community, land and family is thus critical for Aboriginal people, as many suffer from loss, grief and trauma. Aboriginal people experience higher rates of disadvantage than other population groups in Australia, including poverty, inadequate housing, and physical health problems. Aboriginal people are often reluctant to access mainstream services due to a lack of cultural awareness of service providers, experiences of discrimination, racism and past practices of institutionalisation and forced removal.⁸⁴

Hence, the experience of admission to an acute mental health inpatient unit therefore may be particularly distressing for Aboriginal people if the services are not provided in a culturally competent and safe way and may deter future engagement with mental health services. The MHCC has been working to increase engagement with Aboriginal Victorians and improve our understanding of their experiences with mental health services and where service and system improvements can be made to ensure that services are accessible and culturally safe. The MHCC has worked with the Victorian Aboriginal Community Controlled Organisation (VACCHO) on ways of making our office culturally responsive and safe for Aboriginal people and to develop resources to ensure that Aboriginal people in Victoria have access to culturally appropriate information about their rights under the Act and how to make a complaint and have their distinct culture and identity recognised and responded to. While the MHCC has received limited complaints about issues of access or the appropriateness of services for Aboriginal people, some themes that have been raised include:

- people being unable to access an Aboriginal health or mental health worker when requested
- services not accommodating or responding to requests for workers of a specific gender, to meet the cultural needs of Aboriginal consumers.

It is clear that dedicated effort, resources and strategies are required to make all parts of the mental health system, including the MHCC, culturally safe and competent, and having more Aboriginal staff in all parts of the system as well as Aboriginal controlled services will be central to achieving this. Any redesign of service approaches and systems to ensure culturally competent and safe services must be driven and shaped by Aboriginal Victorians and uphold the principles of self-determination and commitments contained in the *Korin Korin Balit-Djak* overarching framework for action to improve the health, wellbeing and safety of

⁸⁴ Department of Health 2011, *Service guideline on gender sensitivity and safety*, Victorian Government, Melbourne

Aboriginal Victorians, and the *Balit Murrup* framework for Aboriginal social and emotional wellbeing in Victoria.⁸⁵

Women and girls

Women and girls may face particular issues that both affect their wellbeing and likelihood of experiencing mental health issues and may make their experiences of mental health services more negative due to a lack of understanding of or response to these issues by mental health services.

Recent Australian statistics estimate more than one in five women aged 18 years or older has experienced sexual violence.⁸⁶ More specific nationally representative data identifies that 15 per cent of Australian women have been sexually assaulted.⁸⁷ The MHCC's *Right to be Safe* report highlighted that women often feel unsafe in mixed gender inpatient settings, with significant numbers of women reporting experiencing sexual activity, harassment, intimidation or assault while accessing acute mental health inpatient treatment in Victoria. This report also drew attention to the high proportion of women accessing acute mental health services who are likely to have a history of trauma, and the risks of significant harms from breaches of sexual safety and also the use of restrictive interventions.⁸⁸ As discussed in section 4.8, the recommendations in this report include a range of strategies to increase women's sexual safety on inpatient units, trauma-informed care and improved infrastructure, such as the piloting of single-gender units (see Appendix C).

Women are also more likely than men to experience family violence,⁸⁹ which impacts their mental wellbeing as well as their experience of mental health services, depending on how well those issues are recognised and responded to by mental health services. The MHCC has received complaints or has heard about people's experiences through broader engagement work about the following issues:

- services seeking to involve specific carers or family members in treatment planning despite the consumer advising of family violence
- consumers being discharged to unsafe arrangements including return to the family home in circumstances where they have advised the service of family violence
- consumers feeling disbelieved by services and/or not referred to other support agencies when disclosing family violence.

The recent investment in improving responses to family violence concerns by mental health services is welcomed, and evaluation of this investment must involve consumers who have experienced family violence.

⁸⁵ See <<https://www.dhhs.vic.gov.au/publications/balit-murrup-aboriginal-social-and-emotional-wellbeing-framework>>

⁸⁶ Australian Bureau of Statistics 2013, 4906.0 – *Personal Safety*, ABS, Belconnen.

⁸⁷ Rees S, Silove D, Chey T, Ivancic L, Steel Z, Creamer M, Teesson M, Bryant R, McFarlane AC, Mills KL 2011, 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function, *JAMA Network*, vol. 306, no. 5, pp. 513–521

⁸⁸ See sections 2.3.3.2 and 2.4.3.1 in Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018,

⁸⁹ Department of Premier and Cabinet 2017, *Free from violence: Victoria's strategy to prevent family violence and all forms of violence against women*, Victorian Government, Melbourne.

LGBTI people

It is well established that LGBTI people tend to experience poorer mental health due to issues including discrimination, abuse, access to services and stigma. There is evidence that mental health inpatient settings can also be unsafe environments for LGBTI people, with people reporting harassment or threatening behaviour from other people accessing inpatient treatment. These issues have been the subject of complaints to the MHCC, including a highly traumatic incident of 'hate speech' and assault that occurred during the period of the postal survey on marriage equality. Since establishment, the MHCC has actively engaged with the LGBTI community to promote awareness of our office and to develop approaches that inclusive and safe for people to raise their concerns.

In addition, consultations for the MHCC's sexual safety project indicated that despite some services actively taking steps to ensure their services are safe and appropriate for trans and gender diverse people, some trans and gender diverse people accessing mental health services continue to experience a range of issues in their interactions with staff including:

- misgendering through use of inaccurate pronouns or first names,
- privacy issues including invasive and inappropriate curiosity about a person's body
- disclosure about the person's gender identity without the person's consent (for example, by publicly identifying the person as trans or gender diverse).⁹⁰

Services therefore need to take a proactive approach to ensuring that they provide safe and affirming environments for all LGBTI people, including the development of gender-sensitive LGBTI-inclusive policies and practices, to improve peoples' experiences of mental health services and therefore the likelihood of better health outcomes and continued engagement with mental health services.

Culturally and linguistically diverse communities

Complaints received by the MHCC reveal that people from CALD backgrounds have experiences of not being able to access interpreters during inpatient treatment, particularly during short admissions. While logistical difficulties are acknowledged, strategies to ensure access to interpreters during inpatient treatment must be prioritised to ensure that people's rights under the Act and the Charter are upheld. This is of particular concern where people are compulsory patients. Access to an interpreter is essential to ensure people are able to make or participate in decisions about their treatment and care, and to enable clinicians to make accurate assessments of whether the criteria for compulsory treatment apply to the person. This must include sensitivity to the role of culture in the person's beliefs and experiences about mental illness. People from refugee backgrounds in particular are likely to have experienced trauma, and consultations by the MHCC have also revealed that this group may also have a fear of authority and be unwilling to complain or raise concerns for fear of delaying discharge. This raises the need for services to be particularly proactive in working with people from refugee backgrounds to support them to speak up about safety or other concerns about their treatment. The MHCC's education and engagement activities seek to promote accessible and culturally responsive approaches for people from CALD and refugee

⁹⁰ See discussion in section 2.4.3.3 in Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018, p77.

and asylum seeker backgrounds and includes the provision of information in 15 community languages.

As noted in *The Right to be Safe* report, additional sensitivities may exist for some individuals and families from some cultural backgrounds in relation to sexual activity, harassment and assault in acute mental health inpatient units, as well as variable practices in services' capacity to recognise and respond to those sensitivities. This points to the need for targeted prevention strategies and sensitive responses to breaches of sexual safety that recognise and respond to the specific needs related to the cultural and religious background and beliefs of the person and their family.

People from CALD backgrounds may also have broader conceptions of family and community than people from other backgrounds. Strong approaches to working with families and carers that are inclusive of the broad range of people who a consumer may identify as relevant to their care and support are particularly important when working with people from these communities to ensure positive mental health and health outcomes.

People with disability or physical health needs

As noted in sections 4.2 and 4.10 above, people with disability or physical health needs can face additional barriers to accessing treatment and in addition may face difficulties getting those needs met while accessing mental health treatment and care. This can have long-term impacts on both mental and physical health. The need for urgent and concerted efforts to address the disparities in physical health outcomes and mortality rates of people with mental illness has been the focus of the national *Equally Well Consensus Statement* and supported by recently published research by the Lancet Psychiatry Commission.⁹¹

The need for improved responses by mental health services to the needs of people with intellectual disability, has also been identified in complaints and investigations by the MHCC. The MHCC has made specific recommendations to both services and to the Secretary of DHHS on the need for '*specific policies, practice guidance and training for mental health staff in relation to the needs of people with a dual disability of mental illness and intellectual disability*' (See Appendix B). The MHCC's education and engagement activities has also sought to promote awareness and accessibility of our complaints processes for people with disabilities, through accessible communications and joint engagement activities with the Disability Services Commissioner.

In addition, and as noted in *The Right to be Safe* report, women with disability (particularly intellectual disability), may be particularly vulnerable to sexual assault within an acute mental health inpatient environment⁹², and services' infrastructure, risk assessment and treatment

⁹¹ National Mental Health Commission, *Equally Well Consensus Statement* 2017 <<https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf>>; Firth, J et al '*The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness*' The Lancet Psychiatry Commission, Volume 6, Issue 8 pp675-712, 2019

⁹² Benedet J, Grant I 2014, 'Sexual assault and the meaning of power and authority for women with mental disabilities', *Feminist Legal Studies*, vol. 22, no. 2, pp.131–154, Chenoweth L 1996, 'Violence and women with disabilities: silence and paradox', *Violence Against Women*, vol. 2, no. 4, pp. 391–411.

planning must identify and respond to this vulnerability to prevent people experience violations of their rights and safety while accessing mental health treatment.

People with co-existing alcohol and drug problems

As noted in sections 4.2 and 4.10 above, people with co-existing alcohol and drug problems report concerns that they face discrimination in attempting to access mental health services. This is of particular concern given the high level of trauma among people accessing mental health services and the possibility that alcohol and drug problems can often be a result of people's attempts to self-medicate as a way of coping with previous trauma. Access to appropriate services that can treat mental health, addiction and underlying trauma is critical for people to be able to experience good health and mental health outcomes.

Older people

Complaints to the MHCC have identified the particular risks of poor mental and physical health outcomes for older people receiving treatment in aged persons' mental health residential care facilities, known also as 'psychogeriatric nursing homes'. As discussed above in section 4.4, the MHCC has dealt with complaints about serious allegations of abuse and neglect of residents of an aged persons' mental health residential care facility, including concerns about the use of restrictive practices, and has made recommendations to the Secretary of a number of recommendations to the Secretary of the Department of Health and Human Services to address the gaps in the current safeguards and oversight for consumers in these facilities(See Appendix B).

The MHCC has also contributed to the '*Tango Project*' by Alice's Garage which aims to improve responses to the difficulties (including abuse and discrimination and poor health outcomes) LGBTI elders (aged 65 years and older) face based on their LGBTI identities. A significant number of LGBTI elders who experience difficulties don't access advocacy or complaints services due to factors such as not feeling safe or entitled to do so. This project sponsored by Victoria's Gender and Sexuality Commissioner aims to promote the awareness and confidence of LGBTI Elders to access complaint and advocacy services.⁹³

Younger people

The mental health challenges risks and challenges faced by young people, particularly the alarming suicide rates of young people from Aboriginal and LGBTI communities, have been well documented and widely recognised. The MHCC's education and engagement activities have recognised the importance of engaging with young people in different ways to support them in building positive relationships with mental health services and confidence to raise any concerns about their experiences. Approaches have included the youth art engagement project '*Different Faces of Mental Health*',⁹⁴ use of social media, education activities with youth mental health services, and the involvement of two dedicated youth consumer positions on our Advisory Council.

⁹³ See < <https://alicesgarage.net/tango-project/>>

⁹⁴ See sections 'Education and Engagement' in MHCC Annual Reports 2016 and 2017 for an outline of this project and outcomes.

People from rural and regional communities

The MHCC has dealt with a range of complaints that highlight the significant challenges of access to mental health services faced by people living in rural and regional communities. These issues include the lack of choice or availability of services, significant risks associated with people living in isolated locations with access to firearms and significant time delays in crisis responses due to distance and availability of staff. The MHCC has contributed to several *Australian Rural and Remote Mental Health* symposiums which focus on strategies to address the particular mental health challenges for people living in these communities.⁹⁵

6. What are the needs of family members and carers and what can be done better to support them (Q6)

The needs of families and carers are broader than those that arise in relation to care and treatment provided to a consumer. However, the MHCC's commentary about the needs of families and carers largely relates to experiences that arise in relation to their caring role and their role in supporting the treatment and care of consumers, as these are the issues that are primarily raised in complaints.

The Act does not provide for carers to make a complaint to the MHCC on their own behalf, unless the consumer consents to the complaint being made. While it is acknowledged that in many instances consumers and carers may have different perspectives about treatment, and that consumer autonomy should be respected where there is disagreement, carers are currently unable to make a complaint to the MHCC about their own experiences with mental health services unless the consumer consents or there are special circumstances which would enable the MHCC to accept the complaint without the consumer's consent. For example, a carer would be unable to make a complaint about a rude or unempathetic interaction with staff, or about the lack of support or referral options provided to a carer, without consumer consent. While the MHCC works with carers in these circumstances to support them to raise their concerns with the service directly, this is a current gap for carers and limits to some extent the information available to the MHCC in relation to the experiences of carers.

As an overarching comment, it is important that services recognise the variety of ways that people may conceptualise family, carers and support people. As noted in section 5 of this submission, people from Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) backgrounds may have a broad conception of family, and services must respond to this in their approaches to working with these consumers and their families. For people in some communities, particularly the LGBTIQ+ community, the idea of family of choice – friends and other support people – may be much more relevant than family of origin or birth. Moreover, the role of young carers and their particularly needs and required supports, must also be considered by mental health services in their approaches to working with families and carers.

⁹⁵ <https://anzmh.asn.au/rrmh/>

The mental health principles outline that carers for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery whenever this is possible, and have their role recognised, respected and supported. Complaints received by the MHCC relating to families and carers' experiences with mental health services include:

- services not taking the views of families and carers into account when making treatment decisions
- inadequate communication with families and carers
- inadequate, unsafe or premature discharge
- inadequate support or referrals provided to families and carers to support their own wellbeing and their capacity to sustain their caring role
- inadequate or lack of open disclosure following a distressing event, including lack of response to the individual needs of families and carers.

Involving families and carers in treatment decisions

In complaints relating to failure of services to take into account the views of carers and families in regard to treatment, carers and families describe:

- not being listened to when they advise services when the consumer has become unwell
- not being involved in or listened to by staff in discussions about assessment, treatment, discharge and follow-up treatment
- services failing to discuss with consumers at reasonable intervals whether they would consent to involving family members or carers in treatment following an initial refusal to involve family (noting that consumer attitudes to involving family members and carers can change over time, or that a nuanced discussion may lead to consumers agreeing to share selected information with a carer).
- being dissatisfied with the outcomes of family meetings.

Inadequate communication with families and carers

Themes in complaints about communication with families and carers include:

- not providing adequate information for carers to perform their caring role – for example information about diagnosis, medication, ways to best support the consumer or warning signs that the consumer may be becoming unwell
- staff failing to advise families and carers of the consumer's admission, absence from an inpatient unit without leave, transfer or discharge
- lack of consistency in information provided - 'saying one thing and doing another'
- making changes to leave arrangements without notifying families or carers
- failing to explain Mental Health Act status or changes to treatment orders to families or carers
- delay in responding to calls from family members or carers
- failing to listen to or take into account information provided by family members or carers, particularly in circumstances where a consumer has not provided consent to share information with family members or carers. This reflects a misunderstanding of information sharing provisions which do not limit services' capacity to hear and consider information provided by family members.
- not communicating with families at all.

Inadequate, unsafe or premature discharge

The MHCC has also received many complaints relating to inappropriate discharge, some of which were made by family and carers. These complaints are predominantly about unsafe or premature discharge, inadequate discharge, dissatisfaction with discharge plans, and inadequate communication of information relating to discharge. Some of the themes in these complaints include concerns:

- about discharge of family members from inpatient units while they were still unwell, particularly in the context of repeated admissions where families and carers felt that a longer admission would promote a better outcome
- from families or carers for their safety or that of others, if the consumer were to be discharged early
- that consumers were discharged into unsuitable accommodation or unsafe situations (including boarding houses or motels), and without adequate support or follow-up provided
- that consumers were discharged to the family home without prior discussion with the family, including in instances where family members were concerned for their own safety or ability to provide adequate care and support to their family member for reasons including being overseas, interstate or otherwise absent from the family home
- unsafe or premature discharge by mental health staff in emergency departments, where consumers were deemed by staff not to be at risk to themselves or others and thus not requiring admission, despite their unwell state. Unsafe or premature discharge from emergency departments includes complaints where alcohol or drug affected consumers have been discharged from an emergency department in the middle of the night, without a safe way to get home and without the service making an effort to contact a family member or carer.

Failure to communicate with families about treatment (including about discharge decisions) has contributed to serious adverse outcomes for consumers in a number of complaints made to the MHCC.

Inadequate support or referrals provided to families and carers to support wellbeing

Families and carers have noted the complexity of the mental health service system and of the other services that their loved one may be engaged with, and their need for greater support to navigate and understand the system. This includes identifying and receiving support to access services that families and carers may be able to access to support their own wellbeing.

In the MHCC's broader engagement activities, it has been noted that the mental health principle that children, young people and other dependents of persons receiving mental health services should have their needs wellbeing and safety recognised and protected⁹⁶ is variable in its implementation and that services need to have more conversations with the consumer at the point of initial engagement about who is involved and important in their lives,

⁹⁶ s 11(1)(j) *Mental Health Act 2014* (Vic)

and whether there may be actions that the service needs to put in place to ensure those people/children are supported if required.

Inadequate or lack of open disclosure, including lack of response to the needs of families and carers

Families and carers' experiences following a distressing event have also been raised in complaints to the MHCC. *The right to be safe* report outlined a number of shortcomings in services' approaches to open disclosure when responding to sexual activity or alleged sexual assault the themes of which are also evident in other complaints to the MHCC. These include:

- **Timeliness:** undue delays in informing family and/or carers of distressing events even where a consumer has consented to information being shared with their family or carer. This can add to the distress experienced both by the consumer and their family or carers, particularly as the family is then not able to provide immediate support to the consumer.
- **Preparation:** failure to plan for open disclosure leading to perceptions of a lack of transparency
- **Support for individuals and families:** including the involvement of appropriately trained social workers, trained patient advocates, pastoral care, consumer or carer consultants or peer workers, or culturally appropriate supports in open disclosure processes to better support consumers, families and carers through these processes and to link them to any psychological or other supports they may need following the open disclosure process.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers (Q7)

Themes from complaints to the MHCC point to the importance of the mental health workforce being supported and enabled to work in ways that are person-centred and support individual recovery. To achieve these aims, we suggest that mental health workforce issues that should be considered include:

- the need to attract a workforce that has the appropriate skills, attitudes and capabilities required to provide person-centred, trauma-informed, recovery-oriented treatment and care that supports people experiencing mental health issues and mental illness to exercise agency and choice in their treatment. This includes dedicated strategies to supporting the role and development of the peer workforce .
- the need to employ the lived experience workforce to a scale that achieves a critical mass to sustain and support this workforce and build on existing peer led and delivered initiatives
- the need to attract a workforce that can ensure support is available to people who most need specialist care and treatment. We note the impact of high throughput in mental health services on the length and nature of care and treatment that people may receive.

- the need to ensure that the workforce has an appropriate mix and diversity to provide the kinds of care and treatment that people with mental illness find helpful in helping them in their recovery, noting in particular that people often express a wish for talking therapies, peer support or other interventions that could be used alongside or as an alternative to the primarily medication-based treatment options available through public clinical mental health services.
- whether the skills and capabilities of the existing mental health workforce are being used to the greatest extent possible. Case management models of care often used in tertiary mental health services may mean that staff with specialised skills, for example in providing psychological interventions, may not have the opportunity to use these skills to the greatest extent possible.
- whether the health and mental health workforce needs additional support to develop the skills and capabilities required to provide person-centred, trauma-informed, recovery-oriented treatment and care,
- the need to address the impact of high demands on services on the capacity of staff to work in these ways, and
- the likelihood that providing support and time for people to work in these ways will improve attraction and retention of the desirable workforce.

In particular, we note the need for health workforces to understand the high prevalence of previous experiences of trauma, and the impact of this on people's experiences of accessing public clinical mental health services. Many people with previous experiences of trauma are re-traumatised by their experiences in mental health services, particularly where coercive practices including compulsory treatment and restrictive interventions are used or where people are or feel physically or sexually unsafe. As discussed in previous sections, these experiences can also lead to people avoiding further engagement with mental health services, which can have serious consequences including further deterioration in mental health and adverse outcomes.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities (Q8)

A lack of participation in and connection to community life can be both a cause and a consequence of people's experiences of mental health challenges. As outlined elsewhere in this submission, people experiencing mental ill-health face barriers to engaging with the community (including discrimination as well as barriers created by the way services are provided), and lack of engagement with the broader community can also contribute to worsening people's mental and physical health and wellbeing, having direct impacts on people's ability to recover and lead a self-defined meaningful life. It is important to note that what is meaningful and important to an individual may or may not include economic participation, but that participation in community life brings value both for the individual and for the community regardless of whether that participation includes paid employment.

There are a range of opportunities for people's opportunities to participate in and connect to community life to be improved. Many of these rely on improvements to the way services are provided that are outlined in other areas of this submission, as well as broader system or community change and are summarised as follows:

- Autonomy, choice and supported decision making (section 4.5) and recovery-oriented, holistic treatment (section 4.11): For people to be able to participate fully in the community, their views and preferences about what is important and meaningful to them must inform and drive treatment and recovery planning, and they must be supported to make or participate in all decisions about their assessment, treatment and recovery. As outlined in section 4.5 of this submission, complaints and feedback to the MHCC indicate that this is not the experience of many consumers.
- Stigma and discrimination (section 1): the stigma and discrimination faced by people with mental illness directly impacts opportunities including but not limited to access to employment and equitable access to treatment for physical health conditions,
- Access (sections 4.2 and 4.3): as discussed in these sections, some people with particular diagnosis or co-occurring conditions face additional challenges in accessing appropriate services. If these services cannot be accessed and people are unable to achieve their best possible mental and physical health outcomes, their opportunities to engage in broader community life are likely to be limited. Young people, older people, people from rural and regional areas, Aboriginal people, people from culturally and linguistically backgrounds, refugees and migrants, LGBTIQ+ people, and people with disabilities may all also face additional barriers to accessing appropriate and safe services to support their recovery, which must be addressed for these groups to have the opportunity to fully engage in community life.
- Physical health (see sections 4.2 and 4.10): people with mental health challenges face a range of physical health challenges including concerns about the side-effects of many mental health medications, as well as lack of adequate and holistic treatment planning to respond to their broader physical health needs and proactively manage side-effects of medication including weight gain. Neglect of physical health not only impacts people's ability to engage with the community during their life, but also has severe and alarming impacts on people's lifespan, with people with mental illness dying on average 20 years earlier than a person without mental illness.⁹⁷.
- Service linkages and pathways (4.12): as discussed in this section, many complaints to the MHCC raise issues about the inter-relationship between the various components of the mental health system, and the interface with other services and agencies. These interface issues can impact significantly on people's recovery and therefore their ability to participate fully in community life and include, for example, lack of continuity of care between health services, or lack of referral and access to other human services including alcohol and drug services and disability services.

⁹⁷Firth, J et al 'The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness' *The Lancet Psychiatry Commission*, Volume 6, Issue 8 pp675-712, 2019

9. Thinking about what Victoria's mental health system should ideally look like, what areas and reform ideas should the Royal Commission prioritise for change (Q 9) &

What can be done now to prepare for changes to Victoria's mental health system and support improvements to last (Q10)

Throughout this submission, the MHCC has focused on the areas about which we have accumulated knowledge through people making complaints to our office. There are many areas within the scope of the Royal Commission that are largely outside the scope of the MHCC's expertise that are necessary and important to achieving significant change (including, for example, addressing stigma and discrimination in the broader community or access to services outside of the public mental health system that can support improved mental health). However, the MHCC's observations on priorities for reform and change within public mental health services include culture change, prioritising human rights, building on the existing lived experience workforce as part of workforce development initiatives, and increased resources for the mental health system as a whole.

As noted earlier in this submission, a key priority put forward by our Advisory Council members for the Royal Commission to consider is the need to prevent the violations of human rights that can occur within the current mental health system. This includes considering the role of culture in influencing how services are provided. Without culture change in mental health services that places human rights, safety and self-determination at the core of service provision, people's experiences are unlikely to significantly change, even with the addition of further resources to the mental health system.

Culture change is complex and takes time. However, there are also strong building blocks within Victoria that can be used to support culture change, including the Centre for Mental Health Learning, a burgeoning lived experience workforce, and many consumers, families and dedicated mental health clinicians who have a strong desire to work together in ways that support people's self-determination and recovery.

There are significant opportunities to expand the role of the lived experience workforce and increase people's access to peer support, in various areas of the mental health service system. This submission has noted various opportunities for increased lived experience presence to provide peer-based support to people experiencing mental ill-health and note our support for the strategies recently released to ensure adequate support for this workforce as it develops.

The MHCC acknowledges that there are significant pressures on acute mental health services, which are attempting to provide services to more people, who are becoming increasingly unwell, without additional staffing or appropriate or adequate infrastructure. It would be extremely difficult to achieve human rights-based, recovery-oriented, holistic mental health services within the constraints of the current system and it is clear that additional resources are needed. However, consideration of *which* resources are needed is important. While Victoria has an extremely low rate of acute mental health beds per population and this needs to be addressed, the full range of possibilities for additional

resources must be considered, with advice and input from people with lived experiences about what range and type of services would be of most assistance in helping people to access services early in the course of an episode of ill-health or distress, and to stay as well as possible.

11. Additional considerations for the Royal Commission (Q11)

In undertaking the sexual safety project, the MHCC applied a framework of three levels of intervention, being primary, secondary and tertiary interventions to identify the key issues and actions required to ensure people's sexual safety in mental health services. The *Right to be Safe* report used a similar framework to *Free from violence: the Victorian Government's Family Violence Prevention Strategy*⁹⁸, defining the levels of intervention in the following way:

- **Primary interventions** are whole of population initiatives that address the underlying drivers of sexual safety breaches (in this instance, taking a 'whole of system' approach)
- **Secondary interventions** aim to identify and respond to individuals who are at high risk of perpetrating or experiencing sexual safety breaches
- **Tertiary interventions** support people who have experienced sexual safety breaches, hold perpetrators to account and aim to prevent any recurrence.⁹⁹

Many of the recommendations in *The Right to be Safe* report, particularly the primary interventions which deal with governance, leadership, service cultures, trauma informed care are equally applicable to addressing the range of issues discussed in this submission. The MHCC therefore encourages the Royal Commission to consider the detailed discussion of issues and recommendations outlined in *The Right to be Safe* report, and the applicability of a similar framework to inform the formulation of the Royal Commission's recommendations.

⁹⁸ Department of Premier and Cabinet *Free from violence: the Victorian Government's Family Violence Prevention Strategy*, 2017

⁹⁹ Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018, pp30-31

Appendices

Appendix A

Overview of MHCC complaint data

Overall numbers of complaints and enquiries

The annual number of enquiries and complaints¹⁰⁰ made to the MHCC has increased in each year of its operation, rising from 1,456 enquiries and complaints received in 2014-15 to 2,195 in 2018-19. The annual numbers of complaints and enquiries received are shown in Figure 1. The low and generally decreasing proportion of enquiries demonstrates that people have a strong understanding of the role of the MHCC.

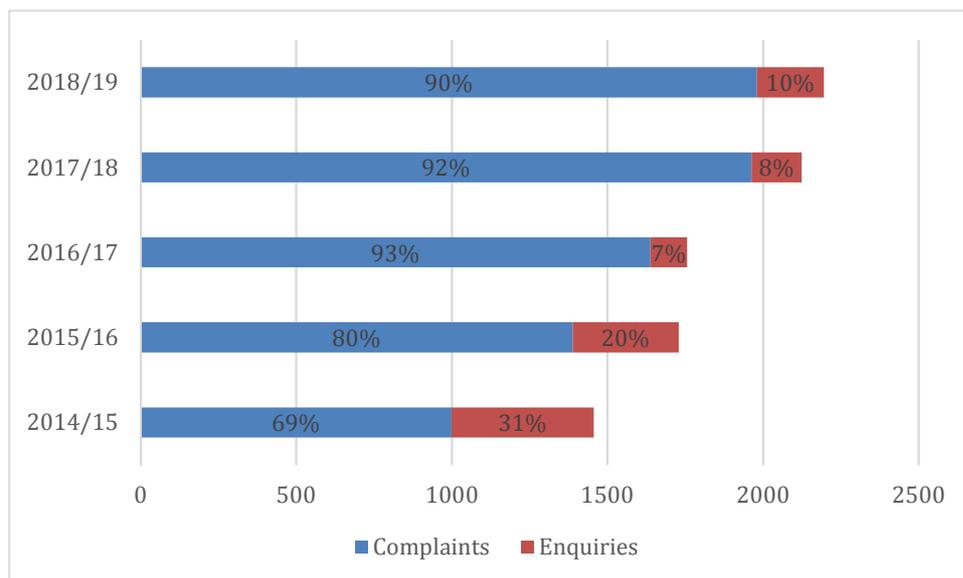


Figure 1: Complaints and enquires received by the MHCC

Who makes complaints?

The annual numbers and proportions of complaints and enquiries received from consumers, family members and carers and others are shown in Figure 2. It is noteworthy that consumers raise most of the complaints and enquiries with the MHCC, accounting for roughly 70 per cent of complaints and enquiries over the five years of our operation, with family members and carers raising approximately 25 per cent of complaints and enquiries. 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.

¹⁰⁰ An enquiry is a request for information, advice or assistance, while 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 legally required (based on Australian Standard AS/ NZS 10002:2014).

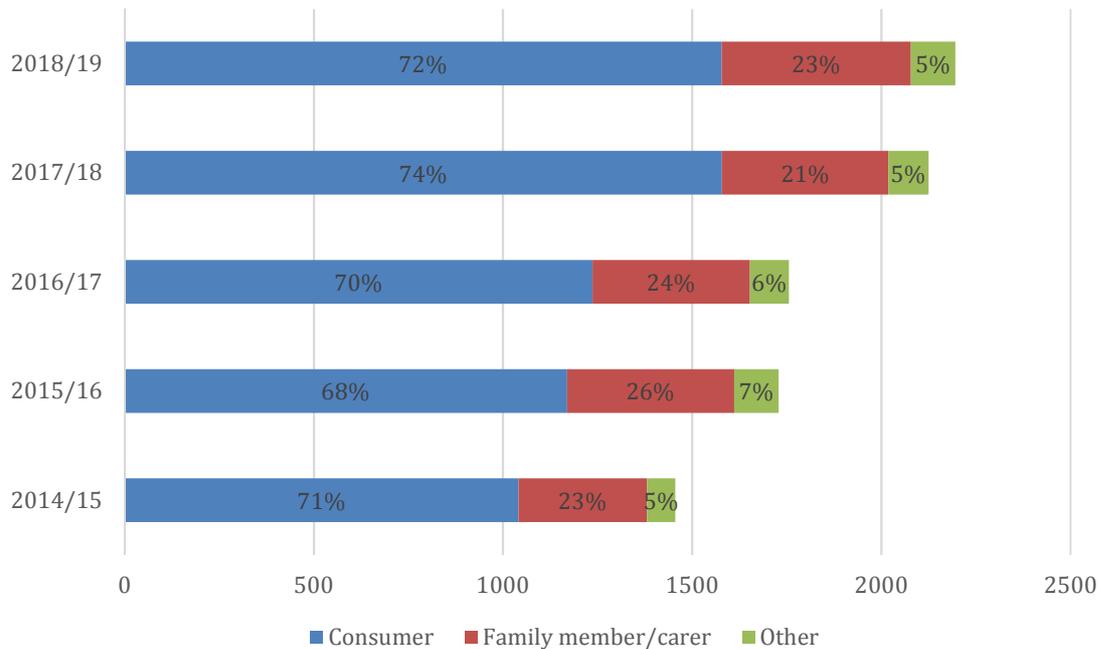


Figure 2: Complaints and enquiries received by the MHCC from consumers, family members/carers and others

Complaints and enquiries by type of service provider

At least 95% of complaints and enquiries in each year of the MHCC’s operation have been about designated mental health services (DMHS) as defined in the Act, while the remainder relate to mental health community support services (MHCSS). The consistent higher proportion of complaints and enquiries about DMHSs is likely because of the significantly higher numbers of consumers accessing these services and that consumers may be subject to compulsory assessment or treatment orders.

Complaints and enquiries by service program type

Where the service program type is able to be identified, approximately 80 per cent of complaints and enquiries each year are about adult mental health services, 5-10 per cent are about forensic services (including services in prisons provided by designated mental health services), five per cent are about aged persons mental health services and five per cent are about child and adolescent mental health services or child and youth mental health services, in addition to the complaints and enquiries about MHCSS.

Of the complaints and enquiries about adult mental health services, almost 60 per cent are about inpatient services. Community mental health services (including community care units and prevention and recovery care services) have typically accounted for 35-40 per cent of complaints and enquiries about adult clinical mental health services.

Complaints made directly to services

The MHCC also collates and analyses data relating to complaints made directly to mental health services. As shown in Figure 3, most complaints from 2015-16 to 2017-18 made directly to mental health services were made to DMHS, again reflecting the higher numbers of people accessing these services and the nature of the treatment/support provided. However, the proportion of complaints about MHCSS made directly to services was greater than the proportion of complaints about MHCSS made to the MHCC.

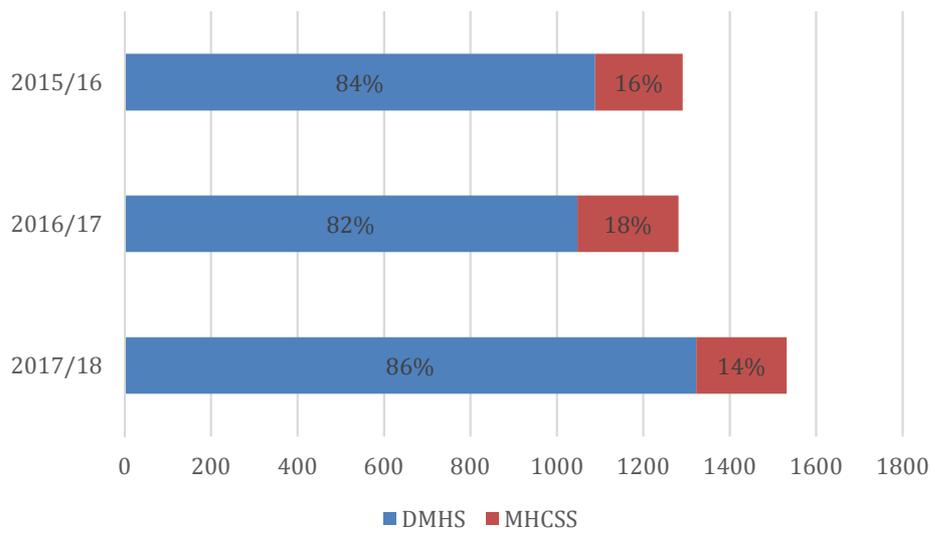


Figure 3: Complaints made directly to mental health services

Appendix B

Summary of Recommendations made to the Secretary of the Department of Health and Human Services and Chief Psychiatrist under s228(j) of the Act on specific issues of quality, safety and rights identified in complaints and investigations 2014/15 to 2018/19

Issue No	Issue	Recommendations	Year
1	Access to mobile phones and other electronic communication device	That the department develop policy and practice guidance on access to mobile phones and other communication devices for consumers during inpatient admissions that is consistent with the right to communicate in the Mental Health Act 2014, recovery-oriented practice, least restrictive practice and the Charter of Human Rights and Responsibilities Act 2006.	14/15
2	Fees charged by Secure Extended Care Units (SECU)	That the department review the program guideline used by health services to charge fees for SECU patients and develop a policy that is consistent with the <i>Mental Health Act 2014</i> and contemporary practice in healthcare settings.	14/15
3	Restrictive interventions in Emergency Departments	That the department review reporting requirements for restrictive interventions as they relate to emergency departments. This would assist in clarifying the respective roles of the MHCC and the Health Services Commissioner (now Health Complaints Commissioner) in assessing and dealing with complaints relating to mental health care in emergency departments.	14/15
4	Categorisation of incidents of alleged assaults in mental health services	That the department consider and address the categorisation and notification of incidents of alleged staff to client' assaults in designated mental health services.	15/16
5	Development of standards and guidelines for investigations by mental health services	That the department consider and address the need to develop guidelines and requirements for investigations which are applicable for designated mental health services.	15/16
6	Reporting protocols for Victoria Police regarding allegations of assaults within mental health services	That the department includes policy and practice guidance for designated mental health services engaging with Victoria Police; and processes for reporting crimes, in the protocols and guidance paper currently being prepared in collaboration with Victoria Police.	15/16
7	Policy and practice guidelines for addressing the needs of people with a dual disability	That the department consider and address the need for specific policies, practice guidance and training for mental health staff in relation to the needs of people with a dual disability of mental illness and intellectual disability.	15/16

8	Clinical guidelines for the management of shared care arrangements with private medical practitioners	That the department consider the need for the development of clinical guidelines for the management of shared care arrangements with private medical practitioners. These issues have been discussed with the Chief Psychiatrist.	17/18
9	Courtyard design in acute inpatient units	That the department consider 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.	17/18
10	Discharge planning	That the department consider reviewing and expanding the discharge planning guideline to address the issues identified in this investigation and the need for effective communication and engagement with consumers, carers and families in discharge planning.	17/18
11	Guidelines for discharge planning and information sharing with families	<p>That the Chief Psychiatrist review guidance to services and consider providing further guidance in relation to:</p> <p>Discharge planning</p> <ul style="list-style-type: none"> the expectation that all reasonable steps are taken to assess a consumer face to face prior to discharge from a community setting to ensure appropriateness for discharge, adequate community supports and that there is no imminent risk of relapse the expectation that where a consumer is to be discharged to an external service provider (e.g. general practitioner) the clinical handover is made to an identified service provider before the consumer is discharged <p>Information sharing</p> <ul style="list-style-type: none"> the circumstances in which information can be shared with families and carers where a consumer is receiving voluntary treatment, and in particular information about discharge planning arrangements where there is an identified carer relationship and a consumer has refused consent to the sharing of information with the carer. 	17/18
12	Sexual Safety	See Appendix C for the comprehensive set of recommendations arising from the MHCC's sexual safety project and investigations.	17/18
13	Use of restrictive interventions in aged care mental health services/ psychogeriatric nursing homes	That the Secretary to the Department of Health and Human Services take steps to provide for a regulatory framework for the oversight and reporting of the use of restrictive interventions in aged care mental health services, whether pursuant to Victorian laws or by advocating for amendment to the Commonwealth regulatory framework in relation to aged care services.	18/19

14	Training of staff of aged care mental health services in identifying and reporting abuse, neglect and restrictive interventions	<p>That the Secretary to the Department of Health and Human Services take steps to ensure that staff of aged care mental health services have access to, and receive, appropriate training in relation to:</p> <ul style="list-style-type: none"> • identifying and reporting allegations of abuse, neglect and unexplained injuries • identifying and reporting incidents of alleged or suspected reportable assaults as required by the Aged Care Act 1997 (Cth) • identifying and reporting restrictive practices. 	18/19
15	Model of care and clinical governance for a psychogeriatric nursing home	<p>That the Secretary to the Department of Health and Human Services review the model of care and clinical governance arrangements for [name of facility], having regard to the issues identified and recommendations made by the OCP and [name of legal firm] investigations, and best practice for aged care mental health services.</p>	18/19
16	Training for staff authorised to make Assessment Orders	<p>That the Secretary and the Chief Psychiatrist consider the adequacy of the training provided to medical practitioners and mental health practitioners employed by designated mental health services about making Assessment Orders under the Mental Health Act 2014, including the training content and requirements, and consider a statewide approach to the development of training resources and a training program.</p>	18/19
17	Care planning, co-ordination and oversight for high-risk consumers with dual disabilities and complex needs	<p>That the department review the processes and framework for the care and treatment of high-risk consumers with dual disabilities and complex needs who are detained in unsuitable facilities and/or subject to prolonged use of restrictive interventions, including:</p> <ul style="list-style-type: none"> • the need for clear processes and a framework for centralised co-ordination, escalation and oversight of care planning • consideration of a model similar to the 'High-Risk Complex Care Child and Youth Panel' proposed by VAGO • processes to ensure that one agency has overall responsibility for care planning and co-ordination, including chairing multi-agency case conferences • consideration of timelines for the development of discharge plans or plans for reduction of the use of restrictive interventions. 	18/19

Appendix C

Summary of Recommendations made to the Secretary of the Department of Health and Human Services (DHHS), Chief Psychiatrist and Mental Health Services under s228(j) of the Act on Sexual Safety:

Excerpts from the report: *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report March 2018*

Overall recommendation to the Secretary DHHS		
<p>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 [and]to address the range of recommendations in this report that draws together and builds on existing initiatives and includes:</p> <ul style="list-style-type: none"> • a clear policy directive that outlines minimum requirements for infrastructure, policies, practices, staff training, reporting, self-assessments and audits that is supported by guidelines (as outlined below) • a clear objective of ensuring sexual safety for people in all acute mental health inpatient units (across all age groups) • guiding principles that reflect human rights, violence prevention (including how gender, disability, race, culture and age may affect people’s experiences of violence) and prioritise working with people with lived experience in developing resources and strategies to ensure sexual safety at both the departmental and service levels • statements that sexual harassment and sexual assault are unlawful and unacceptable and that sexual activity is not permitted in acute mental health inpatient units to ensure all people’s sexual safety • clear definitions of breaches of sexual safety including sexual activity, sexual harassment and sexual assault • strategies to address the levels of primary, secondary and tertiary levels of prevention and intervention in an integrated way • mandatory reporting requirements, including to the police, department and Chief Psychiatrist • revision and expansion of the Chief Psychiatrist’s Guideline, with references to the broader service guideline on gender-sensitivity and safety to support services to meet their responsibilities under the abovementioned policy directive • consideration of how to build capacity in service approaches to ensuring sexual safety, including building capacity and capability in providing trauma-informed care • consideration of how to build on or expand existing peer support approaches to help people to feel, as well as be, safe in acute mental health inpatient units • an implementation, evaluation and monitoring process • performance measures for services and the inclusion of sexual safety in quality and safety reports across mental health services • sexual safety as a key consideration in the development or review of policies, programs and capital works. 		
Primary Prevention		
1	Sexual safety - governance	<p>To establish clear reporting and monitoring mechanisms to ensure accountability for preventing sexual safety breaches. That the department:</p> <ul style="list-style-type: none"> • considers mechanisms for ensuring services are accountable for preventing breaches of sexual safety in acute mental health inpatient units such as policy directives (including prevention of sexual safety breaches in service Statements of Priorities) and reporting and monitoring requirements

		<ul style="list-style-type: none"> • develops ways to measure whether interventions intended to support services to prevent breaches of sexual safety are effective in doing so and take remedial action as required • works with the MHCC to understand the trends observed in complaints and how these relate to, or differ from, trends in incident reporting in services to more accurately identify areas for departmental support or intervention <p>That mental health services:</p> <ul style="list-style-type: none"> • develop a system for monitoring all sexual safety breaches and include these in service risk registers or an equivalent mechanism for monitoring serious quality and safety issues • review service policies and practices to ensure suspected or alleged sexual assaults are classified under the current incident reporting system as ISR2 level incidents at a minimum and are reported directly to senior management for review and decision making
2	Sexual safety - leadership and culture	<p>That the department:</p> <p>As part of the implementation of the recommended 'sexual safety strategy':</p> <ul style="list-style-type: none"> • considers developing co-produced resources for staff to highlight people's experiences of not feeling or being sexually safe within acute mental health inpatient units, and the impacts of these experiences • identifies and shares best practice approaches to ensuring sexual safety, including supportive tools and resources to support staff to identify and respond appropriately to concerns about sexual safety • ensures sexual safety is a key consideration in mental health workforce development to build staff knowledge and understanding of sexual safety, recognition of sexual harassment and sexual assault, and the reasons why sexual activity in acute inpatient environments should be treated as a breach of people's sexual safety • considers ways to establish or use dedicated positions to support sexual safety as part of a broader capacity-building strategy. <p>That mental health services:</p> <ul style="list-style-type: none"> • take steps through training and workforce development to build staff knowledge and understanding of sexual safety, recognition of sexual harassment and sexual assault, and the reasons why sexual activity in acute inpatient environments should be treated as a breach of people's sexual safety • ensure that the guidelines, policies and processes relating to identifying and responding to concerns about sexual safety are clear and easy to follow, and create supportive tools and resources to support staff to fulfil their responsibilities • ensure clear responsibility is allocated within each service for building capacity to ensure sexual safety

<p>3</p>	<p>Sexual safety - trauma-informed care</p>	<p>That the department: In developing policy directives and guidance for mental health services about ensuring sexual safety:</p> <ul style="list-style-type: none"> articulates the principles of trauma-informed care as underpinning effective primary prevention of, and responses to, breaches of sexual safety ensures that information about the prevalence and impact of trauma and likelihood of re-traumatisation of people accessing mental health services is comprehensively addressed within the whole workforce. This should include information about trauma prevalence in particular groups including women, women with disability, Aboriginal people, people from migrant and refugee backgrounds, and people who identify as LGBTI, as well as how people's experiences of trauma may be influenced or compounded by their experiences of discrimination. This should also include information about the impact of restrictive interventions in re-traumatising people. <p>In its role of workforce development and planning:</p> <ul style="list-style-type: none"> ensures that sexual safety, supported decision making and building awareness of the impact of the use of restrictive interventions in re-traumatising people accessing inpatient treatment are considered as a key element of planned workforce development activities in addition to, or as part of, workforce development in relation to trauma-informed care (including existing approaches to learning and development, as well as developing the organisational capability framework) works with education and training bodies to ensure that trauma, particularly in relation to sexual safety in acute mental health inpatient units, is addressed in postgraduate training and education programs (across all disciplines) considers ways to expand, build on or develop peer support approaches that can support people to feel and be sexually safe while accessing acute mental health inpatient treatment. <p>That the Chief Psychiatrist, in the review of the Chief Psychiatrist's Guideline includes:</p> <ul style="list-style-type: none"> more information about the prevalence of trauma and its relationship to people experiencing mental health concerns in their lifetime a greater focus on the links between previous trauma and sexual vulnerability guidance about how trauma-informed care and supported decision making relate to sexual safety in acute inpatient units, including approaches to help people be and feel safe. <p>That mental health services:</p> <ul style="list-style-type: none"> identify opportunities to enhance supported decision making, particularly the development of advance
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		<p>statements with people accessing mental health treatment to identify what would help them to feel and be safe during their admission to an acute inpatient unit</p> <ul style="list-style-type: none"> • encourage and support staff to access training in trauma-informed care and principles • continue work to minimise and eliminate the use of restrictive interventions, acknowledging their effect in re-traumatising people accessing inpatient treatment
4	<p>Sexual safety - infrastructure and design</p>	<p>Ensure unit planning, design and maintenance supports sexual safety, with a particular focus on responding to the needs of women and vulnerable consumers.</p> <p>That the department:</p> <ul style="list-style-type: none"> • explores opportunities to create and pilot single-gender inpatient units within mental health services, with a priority on piloting women-only units • evaluates the effectiveness of multiple approaches to improving sexual safety, including the use of flexible areas to meet individual needs, taking into account models implemented in other states and countries to inform future infrastructure planning • audits existing service infrastructure across all acute inpatient services (including adult, child and youth, aged and specialist inpatient services including forensic services) against a set of criteria of minimum requirements for sexual safety, including lockable bedroom doors, women-only or gender-safe areas, physical systems such as swipe cards to prevent unauthorised access, avoiding communal bathrooms or shared bedrooms, and developing a plan to address identified risks with services • establishes a process for services to self-assess, monitor and report about using infrastructure to support sexual safety • considers ways in which all inpatient units, new and existing, can be designed or adapted to provide flexible areas to meet the needs of varying inpatient populations, including people who identify as trans or gender-diverse • includes minimum requirements related to sexual safety in revisions made to the Adult acute inpatient design guidelines <p>That mental health services ensure that:</p> <ul style="list-style-type: none"> • systems are in place to ensure that infrastructure that supports sexual safety (including access to women-only corridors and bedroom door locks) is prioritised • bedroom doors in all acute inpatient units can be locked by people accessing inpatient treatment, and that policies and procedures are in place to advise people of this possibility and to ensure that staff re-lock doors on exit • systems are in place to prevent unauthorised access to women-only or gender-safe corridors, including both deliberate and inadvertent access • there are systems for assessing and monitoring the appropriate use and maintenance of infrastructure to

		<p>support sexual safety, and for reporting on breaches and the extent to which these areas are not used as intended.</p>
5	Sexual safety - intensive care areas	<p>Develop a plan to improve the safety of ICAs and develop alternative strategies for supporting people who are vulnerable and at risk in these environments.</p> <p>That the department:</p> <ul style="list-style-type: none"> • develops a capital improvement plan for existing ICAs that addresses issues of sexual safety, along with guidelines for designing new ICAs that can designate flexible spaces to accommodate the needs of vulnerable consumers, in particular women or trans and gender-diverse people • considers the purpose, design and staffing of ICAs in pilots of single-gender units, and evaluates the frequency of and reasons for placement in this environment • considers ways for services to support a person who is assessed as being at risk in an ICA environment in the open unit and to use 'specialling' of nurses if additional supervision is required. <p>That the Chief Psychiatrist, as part of the review of the Chief Psychiatrist's Guideline:</p> <ul style="list-style-type: none"> • clarifies that placing a person in an ICA after a disclosure of a breach or concern about their sexual safety is generally inappropriate and potentially re-traumatising and that all other options should be explored • includes advice about actions to address a person's concerns about sexual safety if it is assessed that there is no option but to place such an individual in an ICA. <p>That the Chief Psychiatrist, as part of the review of the ICA guidelines, acknowledges the challenges that the ICA environment presents to ensuring sexual safety, and considers approaches that can mitigate the challenges of providing care in these small spaces.</p> <p>That mental health services:</p> <ul style="list-style-type: none"> • consider options for using existing resources flexibly to ensure sexual safety in ICA environments (for example, where more than one ICA is available, to consider designating one as a women-only ICA at times) • review their policies and procedures to ensure sexual safety is a key consideration in the decision to place a person in an ICA environment, and that where a person is assessed as vulnerable, all other alternatives are explored first • review policies and procedures to ensure that if there is no alternative but to place a vulnerable person in an ICA, that a plan is developed with direct input from the person to ensure their safety

		<ul style="list-style-type: none"> implement strategies and monitoring systems to ensure that risks of breaches of sexual safety are actively managed in ICA environments.
Targeted Prevention		
6	Sexual safety - orientation	<p>Ensure orientation includes working with the person to identify what will help the person to feel safe, as well as clarifying that sexual activity is unacceptable, outlining how a person can seek support from staff if feeling unsafe, and the response that can be expected.</p> <p>That the department:</p> <ul style="list-style-type: none"> supports the development of a suite of co-produced resources to: <ul style="list-style-type: none"> support staff to have clear conversations with people accessing inpatient treatment about their right to sexual safety, how to seek help if they do not feel safe, and to clearly explain that sexual activity is not permitted on the inpatient unit support people accessing mental health services to understand their right to sexual safety, and steps they can take and responses they can expect if they report concerns about sexual safety, including how to make a complaint if they are not satisfied with the response. <p>That the Chief Psychiatrist:</p> <ul style="list-style-type: none"> reviews the Chief Psychiatrist's Guideline to include a requirement that orientation includes an expectation that mental health services will support respectful interactions between all people. Accordingly, people accessing inpatient treatment and staff have a right to be free from sexual harassment, and staff must take action to prevent and respond to reported or observed sexual harassment. <p>That mental health service providers:</p> <ul style="list-style-type: none"> have systems in place to ensure that a verbal and written explanation is routinely provided to people accessing mental health treatment that clearly states that sexual activity is not permitted at orientation (where this explanation cannot be provided at admission for any reason, services must ensure that this is completed as soon as practicable and repeated as necessary) ensure that orientation includes a discussion that the unit supports respectful interactions between all people and that staff will take action to prevent and respond to all reported or observed breaches of people's sexual safety including sexual harassment and suspected or alleged sexual assaults ensure that safety plans are developed for and in conjunction with all people accessing inpatient treatment.

7	Sexual safety - risk assessment and management	<p>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.</p> <p>That the department:</p> <ul style="list-style-type: none"> prescribes the core components of a sexual safety risk assessment framework that encompasses perpetrator risk factors, risk factors related to vulnerability and factors related to the physical and dynamic/relational environment of mental health inpatient units to help in assessing the sexual risk of people accessing treatment develops guidance, using a co-production approach, on ways in which mental health services can undertake sexual safety risk assessments jointly with people accessing treatment. <p>That the Chief Psychiatrist, as part of the review of the Chief Psychiatrist's Guideline:</p> <ul style="list-style-type: none"> includes greater emphasis on holistic risk assessment including the need to assess factors that may cause vulnerability, non-sexual violence and aggression and the physical and relational environment of the inpatient unit when assessing the sexual risk of people accessing treatment specifies the requirement for risk assessments (including the reasons for an assessment) and plans to manage identified risk to be clearly identified at handover. <p>That mental health service providers</p> <ul style="list-style-type: none"> ensure that sexual safety risk assessments encompass potential perpetrator risk factors, risk factors related to vulnerability and factors related to the physical and dynamic/relational environment of the inpatient unit review their processes to ensure that risk assessments and associated reasons for the assessment and plans are clearly identified at handover points and that staff are aware of these requirements consider, using a co-production approach, ways to undertake sexual safety risk assessments jointly with people accessing treatment ensuring services use existing systems to identify and respond to known perpetrator risks.
Tertiary Interventions: responses to sexual safety breaches		
8	Sexual safety - trauma-informed care responses	<p>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.</p> <p>That the department:</p> <ul style="list-style-type: none"> ensures the minimum skills and capabilities expected of all mental health service staff in responding to

		<p>disclosures and breaches of sexual safety, as well as the skills and capabilities required to lead a trauma-informed approach to treatment following sexual safety disclosures, are defined in the planned organisational capability framework</p> <ul style="list-style-type: none"> • considers the development of a co-produced statewide training resource for services on trauma-informed care as it relates to sexual safety. <p>That the Chief Psychiatrist, in the review of the Chief Psychiatrist's Guideline:</p> <ul style="list-style-type: none"> • includes a requirement that consumers who have engaged in sexual activity, as well as consumers involved in other breaches of sexual safety, be offered the opportunity for counselling or psychological support • outlines the responsibilities and decisions required by the authorised psychiatrist or delegate in responding to an incident or allegation of sexual activity or assault. <p>That mental health services:</p> <ul style="list-style-type: none"> • develop approaches to ensure that initial responses to breaches of sexual safety, particularly sexual activity, alleged sexual harassment and sexual assault, are led by a person or persons with the appropriate skills and capabilities to provide a trauma-informed response • ensure they have systems and processes in place to enable medical reviews to be conducted by senior clinical mental health staff, including on-call staff if necessary • have systems in place to ensure that any trauma history is transferred from community teams to inpatient staff when a person is admitted, and that information about trauma experienced during an inpatient admission, including any required follow-up by community teams, is efficiently and effectively transferred • develop or enhance protocols with trauma-specific services (including CASA) to improve consumers' access to these services following an alleged or suspected assault. This may require the development or further enhancement of partnerships with relevant services
9	Sexual safety - open disclosure	<p>Develop specific guidance and approaches for managing open disclosure in relation to sexual safety breaches, ensuring that cultural, religious, communication and other needs are responded to, and that staff are supported in conducting open disclosure.</p> <p>That the department:</p> <ul style="list-style-type: none"> • develops guidance for mental health services in open disclosure processes that includes specific considerations and guidance for responses to breaches of sexual safety, in particular suspected and alleged sexual assaults. When the scope of the proposed duty of candour is clear, guidance about its application in mental health services should also be provided.

		<p>That the Chief Psychiatrist, in the review of the Chief Psychiatrist's Guideline includes:</p> <ul style="list-style-type: none"> • guidance and expectations of services in conducting open disclosure processes in response to breaches of sexual safety, consistent with the ACSQHC's Open disclosure framework and including the areas of concern noted in this report. In particular, this should include consideration of the likely response of families and/or carers to the disclosure of sexual activity or sexual assault of their family member while an inpatient, as well as the cultural, religious, communication and other support needs of the person at the centre of the event and their family or carer. <p>That mental health service providers review their open disclosure policies and practices to consider the matters outlined in this report. Particular consideration should be given to:</p> <ul style="list-style-type: none"> • reviewing the service culture as it relates to open disclosure, including reviewing the training provided to staff regarding open disclosure to ensure this includes a focus on the underlying principles that open disclosure is a right of people accessing mental health treatment, as well as representing good clinical practice and being of benefit to the mental health service • ensuring adequate supports are available for staff participating in open disclosure, including support from a staff member trained and experienced in conducting open disclosure processes • reviewing the support mechanisms available for individuals, families and carers participating in an open disclosure process to ensure that the support a service proactively offers is responsive to cultural, religious, communication or other support needs • ensuring that individuals who experience breaches of sexual safety within an acute inpatient unit, and their family or carers, have the opportunity to express their views about the breach including views about what would prevent future breaches • ensuring that the service has mechanisms to ensure the views of individuals, families and carers are considered thematically in quality improvement activities as well as in relation to individual sexual safety breaches. The opportunity to express these views as part of an open disclosure process should be in addition to the opportunity to be part of any investigation or review process following the breach. <p>Guidelines, policies and processes will require further review as part of implementing the statutory duty of candour.</p>
10	Sexual safety - reporting to Victoria Police	<p>Develop clear guidance about services' duty to report a suspected or alleged sexual assault to Victoria Police, consistent with other service settings.</p> <p>That the department:</p> <ul style="list-style-type: none"> • develops a policy directive for reporting suspected and alleged sexual assaults occurring within mental health services that addresses services' duty to report a

		<p>potential crime to police and is consistent with requirements in other service settings</p> <ul style="list-style-type: none"> works with Victoria Police to clarify policies and protocols in relation to reporting suspected and alleged sexual assaults in circumstances where the victim does not wish to be involved or report the matter, including processes for reporting sexual activity occurring within mental health services. <p>That the Chief Psychiatrist, as part of the review of the Chief Psychiatrist's Guideline:</p> <ul style="list-style-type: none"> reflects the reporting requirements determined through the above process. <p>That mental health services:</p> <ul style="list-style-type: none"> ensure that local policies and procedures are updated to reflect any updated guidance provided about reporting obligations review their policies and procedures immediately to ensure people are assisted and supported to make informed decisions about contacting police following a suspected or alleged sexual assault.
11	<p>Sexual safety - working with Victoria Police to respond to suspected and alleged sexual assaults</p>	<p>Develop clear guidance for mental health services and Victoria Police about responding to sexual safety breaches, including preservation of evidence, documentation, reporting and review mechanisms.</p> <p>That the department either expands its current protocol for mental health with Victoria Police or considers alternate means to provide clearer guidance for services, staff and police on matters including:</p> <ul style="list-style-type: none"> service responsibilities to identify and preserve available evidence including physical evidence and clear, contemporaneous notes of what was observed by staff or reported to them service responsibilities in documenting suspected and alleged sexual assaults advice about pathways to report to Victoria Police and to seek a review of police actions or decisions processes for requesting and supporting the attendance of ITPs at police interviews addressing the recommendations arising from the Beyond doubt report. <p>That mental health services:</p> <ul style="list-style-type: none"> immediately review their policies and procedures to ensure that staff are aware of their responsibilities in preserving evidence, documenting accounts or observations of suspected or alleged sexual assaults, and requesting or responding to queries from police about the need for ITPs continue working with Victoria Police through Emergency Services Liaison Committees to clarify roles and responsibilities as they apply locally

		<ul style="list-style-type: none"> work to develop local pathways and protocols to respond to the revised guidance, when available
12	Sexual safety - investigation standards	<p>Develop clear policy and guidance outlining the thresholds and requirements for investigations and other review processes, as well as considering external oversight of decision making about the necessary level of review of suspected or alleged sexual assaults that is consistent with the requirements of other service settings.</p> <p>That the department:</p> <ul style="list-style-type: none"> develops guidance for clinical mental health services that outlines thresholds and requirements for conducting formal investigations and other review methodologies (this guidance should be consistent, as far as practicable, with the guidance contained in CIMS and should provide for consumer/carer involvement) reviews the external oversight of investigations and reviews for suspected or alleged sexual assaults occurring within mental health services, compared with the equivalent requirements set out in the CIMS in other service settings. <p>That mental health services:</p> <ul style="list-style-type: none"> review their investigation processes to ensure that incidents and alleged breaches of sexual safety: <ul style="list-style-type: none"> are investigated by appropriately qualified staff external to the unit in which the alleged breach occurred include advice from Victoria Police on the scope and timing of the service's investigation include a review of the records of any co-patients alleged to be involved in an sexual safety breach, as well as staff on duty at the time of the breach, particularly where records are incomplete or otherwise unclear ensure that any investigation into incidents and alleged breaches of sexual safety includes the account and perspective provided by the alleged victim/person at the centre of the concerns, as well as the account and perspective provided by the person raising the concerns (if not the same person) consider opportunities for involving the consumer and carer workforce in activities related to the investigation.
13	Sexual safety - reporting of incidents	<p>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.</p> <p>Ensure reporting requirements are integrated and can consider ways to identify patterns in reported incidents to identify the need for quality improvement.</p> <p>That the department:</p>

		<ul style="list-style-type: none"> • reviews and revises its reporting requirements for suspected or alleged sexual assaults to ensure consistency with the standards of reporting required in other sectors by the Client Incident Management System • considers ways of integrating incident reporting with reporting requirements to the Chief Psychiatrist • requires that alleged breaches of sexual safety in mental health services be categorised under the current the VHIMS system with a minimum rating of ISR2 (with guidance on ISR 1 ratings for incidents assessed as an ‘other type of catastrophic event’) to ensure escalation to senior management for review and response, as well as oversight and monitoring of these incidents • as part of the review and redevelopment of reporting systems, considers the ways in which different levels and types of sexual safety breaches can be reported to help identify patterns that may indicate the need for quality improvement, escalation and different approaches to ensuring sexual safety. <p>That the Chief Psychiatrist:</p> <ul style="list-style-type: none"> • reviews the Chief Psychiatrist’s Guideline to require reporting of all suspected and alleged sexual assaults, rather than ‘occurrences’ • considers options for reviewing sexual activity between consumers, either through increased reporting requirements or through access to incident reports. <p>That mental health services:</p> <ul style="list-style-type: none"> • review their policies, procedures and training to ensure that all staff are aware of the reporting requirements to the Chief Psychiatrist.
14	Sexual safety - documentation standards	<p>Ensure observations or reports are clearly, accurately and contemporaneously recorded using factually accurate terms to describe the nature of any sexual safety breaches.</p> <p>The review of the Chief Psychiatrist’s Guideline should:</p> <ul style="list-style-type: none"> • review definitions and use of terms to remove references to ‘inappropriate sexual activity’ provide guidance on terms that should be used in verbal communication and written documentation • include examples of vague terms and inappropriate language that should not be used, and specific alternatives that would more clearly and accurately record what has occurred during a person’s treatment • specify the need for accurate and contemporaneous nursing observations in relation to any observations or reports of sexual activity, harassment or assault. <p>Mental health service providers should:</p> <ul style="list-style-type: none"> • review documentation practices as part of their standard quality assurance activities, with a view to identifying and addressing vague or unclear practices and providing training where a need for this is identified

15	Sexual safety - discharge planning and referrals	<p>Ensure discharge planning clearly identifies the nature of any breach experienced, as well as planning for future admissions and outlining necessary support and referral for the person and their family/carers.</p> <p>That the Chief Psychiatrist, in reviewing the Chief Psychiatrist's Guideline:</p> <ul style="list-style-type: none"> • notes the need for discharge documentation to include clear and factual descriptions of breaches of sexual safety as well as clearly outlining the referrals and supports required • includes guidance about the need to develop plans for future admissions as part of discharge planning, including by developing advance statements and options for a person to be admitted to a different inpatient unit if admission is required in future • considers the need for referrals and support for families and carers. <p>That mental health services:</p> <ul style="list-style-type: none"> • ensure that discharge planning and documentation accurately reflects the nature of any sexual safety breach or alleged breach as well as the steps required to respond to identified needs • ensure that discharge planning processes consider advance statements or other plans about future admissions, including plans to admit the person to a different unit if an admission is required in future • consider the needs of families and carers as part of discharge planning, including the need to make referrals to carer support services or psychological or counselling supports.
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Appendix D

Complaint Issue Categories used by the MHCC

Explanatory notes:

Level 1 issues are the standard categories in the Victorian Hospital Incident Management System (VHIMS) which is used by public mental health services

Level 2 issues are VHIMS categories which have been adapted to better reflect these types of issues in mental health services

Level 3 issues are additional MHCC categories which aim to capture specific issues in mental health services and the Mental Health Act 2014

Level 1 Issue	Treatment
Level 2 Issue	Responsiveness of staff
Level 3 Issues	Inadequate consideration of views and preferences - compulsory patient *
	Inadequate consideration of views - carer / family / guardian of compulsory patient *
	Inadequate Consideration of Views - Nominated Person of Compulsory Patient *
	Inadequate Consideration of Views and Preferences - Consumer - Voluntary/Status Unknown *
	Inadequate Consideration of Views - Carer / Family / Nominated Person - Voluntary/Status Unknown *
	Inadequate consideration of views - other provider
	Inadequate consideration of views - other (e.g. NGO, GP, guardian, OPA)
	Concerns about staff skills / qualifications
	Lack of care / attention (e.g. not feeling listened to/believed)
	Insufficient staffing
Level 2 Issue	Restrictive Interventions
Level 3 Issues	Seclusion - inappropriate environment / amenities
	Seclusion - inadequate medical review
	Seclusion - inadequate observation
	Seclusion - nominated person / carer not notified
	Seclusion - considered unnecessary
	Seclusion - approved guidelines not adhered to
	Seclusion - inadequate documentation
	Seclusion - lack of dignity / rights
	Seclusion - inadequate authorisation
	Seclusion - not reported to Chief Psychiatrist ^
	Physical restraint - excessive force / alleged assault - clinical staff
	Physical restraint - excessive force / alleged assault - security
	Physical restraint - excessive force / alleged assault - clinical & security
	Physical restraint - lack of dignity / rights
	Physical restraint - considered unnecessary
	Physical restraint - inadequate documentation
	Physical restraint - inadequate authorisation
	Physical restraint - inadequate clinical monitoring
	Physical restraint - nominated person / carer not notified

	Physical restraint - approved guidelines not adhered to
	Physical restraint - inadequate medical review ^
	Physical Restraint - Not Reported to Chief Psychiatrist ^
	Mechanical restraint - excessive force / alleged assault - clinical staff
	Mechanical restraint - excessive force / alleged assault - security
	Mechanical restraint - excessive force / alleged assault - clinical & security
	Mechanical restraint - lack of dignity / rights
	Mechanical restraint - considered unnecessary
	Mechanical restraint - inadequate documentation
	Mechanical restraint - inadequate authorisation
	Mechanical restraint - inadequate clinical monitoring
	Mechanical restraint - nominated person / carer not notified
	Mechanical restraint - approved guidelines not adhered to
	Mechanical Restraint - Inadequate Medical Review ^
	Mechanical Restraint - Not Reported to Chief Psychiatrist ^
Level 2 Issue	Incorrect Treatment
Level 3 Issues	Wrong / inappropriate treatment (e.g. error)
	Statutory process for making or reviewing AO or TTO not followed
Level 2 Issue	Inappropriate Discharge or Transfer
Level 3 Issues	Inadequate discharge information communicated
	Dissatisfied with discharge plan
	Inadequate discharge
	Inadequate transfer
	Unsafe/premature discharge
	Discharged without review
	Inappropriate discharge summary
Level 2 Issue	Inadequate Follow Up
Level 3 Issues	Follow up - inadequate
	Follow up – none
	Inadequate relapse prevention plan
Level 2 Issue	Nutrition
Level 3 Issues	Personal / religious dietary requirements
	Inadequate nutrition
Level 2 Issue	Infection Control
Level 2 Issue	Adverse Outcome
Level 3 Issues	Unexpected complications
	Injury sustained – physical
	Injury sustained - psychological
	Death / suicide
	Self harm / attempted suicide

Level 2 Issue	Suboptimal Treatment
Level 3 Issues	Inadequate treatment planning
	Inadequate therapeutic options
	Inadequate risk assessment
	Inadequate medical review
	Inadequate nursing observations
	Inadequate shared care arrangements
	Inadequate supports to enable supported decision making
	Lack of continuity of care
	Lack of trauma informed care
	Lack of gender sensitive care
	Needs Not Met - Alcohol and Other Drugs ^
	Needs Not Met - Age ^
	Needs not met - cultural
	Needs Not Met - Disability and Communication ^
	Needs not met - medical devices
	Needs not met - mobility aides
	Needs Not Met - Needs, Wellbeing and Safety of Dependents Not Recognised ^
	Needs not met - physical health
	Needs Not Met - Religion ^
	Advance statement - not considered
	Advance statement - written reasons not provided for override
	Advance statement - other issues
	Leave concerns
	Disagreement with Assessment Order
	Disagreement with Treatment Order
	Voluntary patient feels s/he must accept treatment/threat of compulsory treatment
	Least restrictive option not considered
	Rights and dignity of consumer not respected & promoted
	Restriction on communication - phone/electronic
	Restriction on communication - visitors
	Restriction on communication - VLA/statutory bodies
	Second opinion - no access / offer
	Second opinion - delayed
	Second opinion - report not considered
	Second opinion – other
	ECT
Level 2 Issue	Other Treatment issues
Level 1 Issue	Communication
Level 2 Issue	Consent
Level 3 Issues	Person did not have capacity to provide informed consent
	Adequate information to make an informed decision not provided
	Person not provided with a reasonable opportunity to make the decision
	Consent to treatment had been withdrawn

	No consent for medical treatment (non-psychiatric)
Level 2 Issue	Confidentiality or Information Privacy
Level 3 Issues	Privacy breach
	Difficulty accessing personal health information
	Information released / disclosed by staff
Level 2 Issue	Inadequate or Misleading Information
Level 3 Issues	Inadequate / incomplete information / confusing
	Statement of rights - not provided/explained/delayed
	Inadequate communication - about compulsory status
	Inadequate communication - about voluntary status
	Inadequate communication - with nominated person
	Inadequate communication - with family/carer
	Lack of communication - with other provider
	No / inadequate open disclosure
	Insufficient information about MHT process & appeal rights
Level 2 Issues	Other Communication Issues
Level 1 Issue	Conduct & Behaviour
Level 2 Issue	Lack Of Dignity
Level 2 Issue	Rude/Lack of Empathy
Level 3 Issues	Rudeness / lack of respect / discourteous
	Lack of empathy / compassion
	Ignored / lack of attention
Level 2 Issue	Discriminatory Behaviour
Level 3 Issues	Sexuality
	Culture / language
	Aboriginal
	Gender
	Age
	Religion
	Diagnosis ^
	Disability - physical
	Disability - Intellectual/Cognitive
	Disability - Sensory ^
	Disability – Psychosocial
	Substance use
	Other
Level 2 Issue	Inappropriate Relationship (Non-Sexual)
Level 2 Issue	Threats, Bullying or Harassment – Staff
Level 3 Issues	Coercive behaviour

	Alleged threats / intimidation or bullying by staff - clinical
	Alleged threats / intimidation or bullying by staff - security
	Alleged threats / intimidation or bullying by staff - clinical & security
	Alleged verbal abuse by staff - clinical
	Alleged verbal abuse by staff - security
	Alleged verbal abuse by staff - clinical & security
Level 2 Issue	Threats, Bullying or Harassment – Consumer/Other
Level 3 Issue	Alleged threats / intimidation or bullying - by another consumer
	Alleged threats / intimidation or bullying - by visitor/other
	Alleged verbal abuse - by another consumer
	Alleged verbal abuse - by visitor/other
Level 2 Issue	Sexual Misconduct - Staff
Level 3 Issue	Alleged sexual assault by staff member
	Alleged sexual harassment by staff member
Level 2 Issue	Sexual Misconduct – Consumer/Other
Level 3 Issue	Alleged sexual assault - by another consumer
	Alleged sexual assault - by visitor/other
	Alleged sexual harassment - by another consumer
	Alleged sexual harassment - by visitor/other
	Alleged sexual activity with another consumer
Level 2 Issue	Physical Assault – Staff
Level 3 Issue	Alleged physical assault - by clinical staff
	Alleged physical assault - by security staff
Level 2 Issue	Physical Assault – Consumer/Other
Level 3 Issue	Alleged physical assault - by visitor/other
	Alleged physical assault - by consumer
Level 2 Issue	Other Conduct Behaviour Issues
Level 1 Issue	Facilities
Level 2 Issue	Cleanliness
Level 3 Issue	Unclean / unsanitary conditions
	Physical hazards in facility
Level 2 Issue	Accommodation
Level 3 Issue	Environmental issues (e.g. noise, lighting, temperature)
	Bedding / furniture
	Quality of food / meals
	Broken / damaged equipment
	Other accommodation aspects
Level 2 Issue	Security
Level 3 Issue	Ability to Leave Without Agreement/Authority ^

	Property lost / damaged
	Property stolen
	Lack of privacy within accommodation
	Not gender safe environment
	Illicit drugs in facility
	General unsafe environment (e.g. feeling unsafe)
Level 2 Issue	Equipment and Resources
Level 3 Issue	No / inadequate supplies provided
Level 2 Issue	Other Facilities Issues
Level 1 Issue	Diagnosis
Level 2 Issue	Inadequate or Appropriate Assessment
Level 3 Issues	Inadequate assessment process
	Dissatisfied with outcome of assessment
Level 2 Issue	Inadequate or Inappropriate Referral
	No / refusal to refer
	Delay in referral
	Poor referral management
Level 2 Issue	Incorrect Diagnosis
	Incorrect / disputed diagnosis
	Inadequate diagnosis
	No / inadequate explanation of diagnosis
Level 2 Issue	Other Diagnosis Issues
Level 1 Issue	Medication
Level 2 Issue	Refusal to Prescribe or Dispense
Level 3 Issue	Refusal to dispense/prescribe medication
Level 2 Issue	Medication Concerns (Including Errors)
Level 3 Issue	Error - wrong prescription
	Error - wrong medication or dose administered/ omitted
	Unnecessary medication
	Over sedation
	Inadequate clinical documentation
	Side effects from medication
	Known allergy / reaction to medication not considered
	Dissatisfaction with changes to prescribed medication
	Preference for oral over depot medication
Level 2 Issue	Other Medication Issue
Level 1 Issue	Access
Level 2 Issue	Service Availability
Level 3 Issue	Lack or insufficient access to service
	Refusal to admit or treat

	Inaccessible due to distance / public transport
	Delay in assessment
	Delay in treatment
	Refusal to assess
	Dual diagnosis / comorbidity
	Policies and procedures not followed / inadequate
Level 2 Issue	Administration
Level 3 Issue	Poor administrative processes
Level 2 Issue	Inappropriate Fees or Billing
Level 3 Issue	Excessive cost
	NDIS related funding issues
	Billing practises
	Special Needs Not Accommodated
	Language access issue
	Physical access issue e.g. ramp, layout of facility
Level 2 Issue	Other Access Issues
Level 1 Issues	Records
Level 2 Issue	Access to Record
Level 3 Issue	Lack of access to records
	Records not provided 48 hrs prior to MHT hearing
Level 2 Issue	Transfer of Record
Level 3 Issue	Refusal to release records
	Difficulties with transfer of records
Level 2 Issue	Record Keeping
Level 3 Issue	Request to amend / correct records
	Inaccurate / incomplete records
Level 2 Issue	Destruction of Record
	Deletion / disposal of records
Level 2 Issue	Transfer of Information Critical to Ongoing Care
Level 2 Issue	Other Record Issues
Level 1 Issue	Complaint Management
Level 2 Issue	Inadequate or No Response
Level 3 Issue	Local complaints process - inadequate / no response
	Local complaints process - dissatisfied with process
	Local complaints process - dissatisfied with timeliness of response
	Local complaints process - dissatisfied with outcome

Level 2 Issue	Retaliation as a Result of Complaint
	Reprisal / fear of - against consumer
	Reprisal / fear of - against carer
	Reprisal / fear of - against staff / other
Level 2 Issue	Complaint Process Difficult to Navigate
	Local complaints process - information not provided / accessible
	MHCC information / access not provided
Level 2 Issue	Other Complaint Management issues

Note: * compulsory vs voluntary/unknown breakdown of these issues introduced 1 July 2019
^ issue introduced 1 July 2019

Appendix E

Key principles of trauma-informed care and practice and their relationship to delivering sexually safe services¹⁰¹

Trauma-informed care principle	Description	Implications for providing sexually safe care and treatment
Recognition	<p>Recognise the prevalence, signs and likely impact of trauma, including that people may not always identify or disclose their experiences of trauma.</p> <p>Recognise the intrinsic traumatising potential of compulsory treatment.</p>	<p>Services assume most people will have previous experience of trauma and ensure this is incorporated into treatment and care planning. The particularly high prevalence of trauma associated with sexual violence against women is recognised and responded to.</p> <p>Services ensure good information transfer to inform service responses to known trauma.</p>
Prevent re-traumatisation	<p>Understand that operational practices, power differentials between staff and people accessing treatment, authoritarian interactional styles, poorly handled trauma disclosures, blaming language and other features of mental health treatment including providing mixed-gender care, experiences of injustice and the use of compulsory treatment or coercive practices can re-traumatise people.</p>	<p>Services take steps to minimise and eliminate coercive practices.</p> <p>Single-gender treatment is prioritised, particularly in ICAs. Services pay particular attention to whether there is a genuine need for a vulnerable person to be placed in an ICA. Services address behaviours of individuals that may re-traumatise others.</p> <p>In assessment and treatment, avoid using language that inadvertently blames the patient for harm done by others. For example, use 'What happened to you?' in preference to 'What is wrong with you?'</p>
Cultural, historical and gender contexts	<p>Acknowledge community-specific trauma and its impacts. Ensure services are culturally and gender-sensitive and appropriate. Recognise the impact of racism, ableism, sexism, homophobia, ageism and poverty. Recognise the impact of intersectionalities of people's various social identities and the potential of relationships and communities to aid recovery</p>	<p>Services are aware of and sensitive to the extremely high prevalence of sexual trauma in certain demographic groups, notably women and particularly women with intellectual disability and Aboriginal women. Services also recognise the high prevalence of trauma in people who identify as LGBTI and people from migrant and refugee backgrounds. Services recognise that people's experiences of trauma may be compounded by experiences of racism, ableism, sexism, homophobia or ageism.</p>

¹⁰¹ See section 2.3.3 on Trauma Informed Care in Mental Health Complaints Commissioner, *The Right to be Safe. Ensuring sexual safety in acute mental health inpatient units: sexual safety report* March 2018, pp45-55; Framework is adapted from a range of references discussed in the above section.

<p>Trustworthiness and transparency</p>	<p>Services ensure decisions (organisational and individual) are open and transparent, with the objective of building trust. This is critical in building relationships with people with a trauma history who may have experienced secrecy and betrayal.</p>	<p>People are asked about and provided with the supports they need to make their own treatment and recovery decisions so they can maintain agency and are able to exercise choices.</p> <p>Services identify opportunities to make decisions transparently and, where possible, jointly with people accessing services, including undertaking joint sexual safety risk assessments.</p>
<p>Collaboration and mutuality</p>	<p>Services understand the inherent power imbalance between staff and people accessing services and ensure that relationships are based on mutuality, respect, trust, connection and hope.</p>	<p>Services and the department focus on creating environments where therapeutic relationships between staff and people accessing treatment can be developed.</p> <p>The support offered by peers, both formally and informally, is recognised, supported and built on.</p>
<p>Choice and control – supported decision making</p>	<p>Services adopt strengths-based approaches, with people supported to develop self-advocacy and self-determination. This is important as experiences of trauma are often characterised by a lack of control and disempowerment.</p>	<p>Services provide people with the supports they need to make their own decisions. This includes encouraging and supporting the development and use of advance statements as well as engaging support people, advocates and nominated persons to support an individual to make decisions about their treatment.</p>
<p>Safety</p>	<p>Services must ensure that everyone within a service feels and is emotionally and physically safe. This includes feelings of safety through choice and control, and cultural and gender awareness. Environments must be physically, psychologically, sexually, socially, morally and culturally safe.</p>	<p>People are routinely asked what would help them to feel safe in an acute inpatient environment. Reports of feeling physically or emotionally unsafe are validated and specific actions are identified and agreed on with the person and acted on to support them to feel and be safe.</p> <p>Providing single-gender acute inpatient treatment is prioritised.</p>
<p>Pathways to trauma-specific care</p>	<p>People with experience of trauma should be supported to access trauma-specific care.</p> <p>Trauma-specific care should be provided by mental health services (among other services) and be well resourced.</p>	<p>Services ensure all acute inpatient staff are able to respond empathically to disclosures of sexual activity, harassment or assault and support the person to access appropriate services. Services also have clear internal protocols to ensure that any follow-up enquiry, treatment or care is undertaken by skilled and experienced individuals who are able to provide trauma-specific care.</p> <p>Services have clear protocols with trauma-specific services to support effective and efficient referrals.</p>

Appendix F

Framework for implementation of trauma Informed mental health services¹⁰²

The National Health Service's Education for Scotland *Transforming psychological trauma: a knowledge and skills framework for the Scottish workforce* framework outlined four levels of approaches to trauma as follows:

- **Trauma-informed** – defines the baseline skills and knowledge required, and includes recognition of the prevalence of trauma and its impacts, identifying and minimising practices that may cause re-traumatisation while identifying ways to practice that support choice, collaboration, trust, empowerment and safety.
- **Trauma-skilled** – describes the knowledge and skills required by people who have direct contact with people who are likely to have had traumatic experiences, whether or not those experiences are known. The knowledge and skills described include:
 - the ability to relate to all people using trauma-informed principles
 - translating trauma-informed principles into trauma-informed systems and procedures
 - recognising and supporting the need for safety
 - supporting people to identify and access appropriate services
 - meaningfully demonstrating hope and optimism.
- **Trauma-enhanced** – details the knowledge and skills required by workers who have more regular and intense contact with individuals who are known to be affected by traumatic events (including mental health services). Skills required include:
 - recognising how trauma has affected the person's physical and mental wellbeing
 - helping people to identify links between current difficulties and past trauma, including normalising and making sense of current difficulties as adaptive responses to past trauma
 - understanding triggers for the person and advocating for them to ensure systems and procedures do not create re-traumatisation
 - working with the person affected by trauma to evaluate their needs in terms of safety/risk, practical and emotional support, physical and mental healthcare and therapeutic resources
 - working with the person to identify and support referrals to specialist trauma services
 - communicating a willingness and ability to hear a disclosure/discuss trauma and abuse if the individual wishes to disclose
providing an empathic, non-blaming and trauma-informed response to a planned or spontaneous disclosure of trauma and abuse.
- **Trauma-specialist** – details the knowledge and skills required by staff who, by virtue of their role and practice setting, play a specialist role in directly providing evidence-based interventions, offering consultation to inform the care and treatment of those affected by trauma, managing trauma-specific services, leading the development of trauma-specific services, or coordinating multi-agency service-level responses to trauma. Skills and knowledge required include:
 - undertaking a risk assessment that takes into account experiences of previous trauma
 - where appropriate, directly intervening psychologically to manage risk to the person or others

¹⁰² NHS Education for Scotland 2017, *Transforming psychological trauma: knowledge and skills framework for the Scottish workforce*, Scottish Government, Edinburgh; Excerpt from 'Mental Health Complaints Commissioner, *The*

- comprehensively and appropriately assessing current psychological distress and functional difficulties in light of trauma history, taking into account the person's current context and the purpose of assessment
- identifying the person's current coping, resources and protective factors
- reframing 'symptoms' in a way that marks their original function as a means or attempt to cope with overwhelming threat and/or harm
- contributing to safe and effective services and systems by providing trauma-informed/trauma-specific supervision that is underpinned by a robust understanding of trauma-informed practice and supervision models.

The framework provides a useful model to consider in any approach to implementing trauma-informed care in mental health services. It is likely that all of the competencies at the trauma-enhanced level, and many of those described at the trauma-specialist level, would be required for mental health services to successfully implement approaches to care that respond to the prevalence and impact of trauma among people accessing mental health services.