Royal Commission into Victoria's Mental Health System

WITNESS STATEMENT OF DR LYNNE COULSON BARR OAM

I, Dr Lynne Coulson Barr OAM, Victoria's Mental Health Complaints Commissioner (**MHCC**), of Level 26, 570 Bourke Street Melbourne, in the State of Victoria, say as follows:

1 I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

2 I am giving evidence to the Royal Commission into Victoria's Mental Health System (**Royal Commission**) in my statutory role as the MHCC.

Background

Qualifications and experience

3 I was appointed as the inaugural MHCC in April 2014 and have been performing the role and functions of this position since the office commenced operation on 1 July 2014. In addition to establishing this specialist statutory complaints body, I also played a key role in the establishment and operations of the office of the Disability Services Commissioner (**DSC**) in Victoria, holding the role of Deputy Commissioner from 2007 to 2014.

4 I have previously held the role of President of the former Victorian Intellectual Disability Review Panel. I have also served as a member of various state and federal tribunals and statutory bodies, including the Victorian Mental Health Review Board, the Victorian Civil and Administrative Tribunal (**VCAT**), the Victorian Multiple and Complex Needs Panel, and the Administrative Appeals Tribunal as a National Disability Insurance Scheme (**NDIS**) specialist member. In addition to my roles in statutory and regulatory environments, I have extensive experience in leading and delivering support and crisis services, including mental health, disability, out-of-home care, and child and family services.

5 In these previous roles, my work included reviews of the adequacy of investigation processes, tribunal decision-making on allegations of misconduct and abuse, and inquiries into the adequacy of responses to critical incidents. I have also developed resources for service providers on effective approaches to complaint resolution, investigations and safeguarding frameworks.

6 In 2013, I was awarded a Weinstein International Fellowship to study international approaches to accessible and effective dispute resolution. In 2016, I completed doctoral

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

research on statutory conciliation and complaint processes. I hold a Doctor of Juridical Science, Master of Social Work, Bachelor of Social Work and a Bachelor of Arts from Monash University.

7 Attached to this statement and marked "Attachment LCB-1" is a copy of my curriculum vitae.

8 Attached to this statement and marked "Attachment LCB-2" is a list of the abbreviations and acronyms that I use in this statement.

9 Attached to this statement and marked "Attachment LCB-3" is a summary of complaints data received by the MHCC regarding issues about physical health, mobility and other needs of consumers of mental health services.

10 Attached to this statement and marked "Attachment LCB-4" is a summary of complaints data received by the MHCC regarding issues about alleged physical assaults on consumers.

11 Attached to this statement and marked "Attachment LCB-5" is a summary of complaints data received by the MHCC regarding issues related to supported decision making.

Role and responsibilities as Mental Health Complaints Commissioner

12 The office of the MHCC was established under the *Mental Health Act 2014* (Vic) (**Act** or ***Mental Health Act***) as one of the key components of the improved safeguards, oversight and service improvement provisions of the legislation.

13 The office of the MHCC was created to address the significant barriers people experience 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. The office of the MHCC is a unique feature of Victoria's, and Australia's, mental health system.[1]

14 The Act sets out the MHCC's role, powers and functions.[2] The functions of the MHCC include the following:

(a) accepting, assessing, managing and investigating complaints about service providers;

(b) endeavouring to resolve complaints in a timely manner using formal and informal dispute resolution as appropriate, including conciliation;

[1] See paragraphs [103]–[104] for an outline of the advantages of this unique approach.
[2] *Mental Health Act* ss 228–9.

(c) issuing compliance notices;

(d) advising on anything relating to a complaint;

(e) ensuring the procedure for making complaints is accessible;

(f) educating service providers about their responsibilities in managing complaints;

(g) helping consumers resolve complaints directly with service providers;

(h) helping service providers develop policies and procedures for resolving complaints;

(i) reviewing quality and safety issues arising out of complaints and making recommendations and providing information to the appropriate person or agency (eg service providers, the Chief Psychiatrist, the National Disability Insurance Agency (**NDIA**));[3] and

(j) investigating and reporting on anything relating to service providers, at the Minister's request.

15 The MHCC has broad powers to deal with complaints about Designated Mental Health Services and publicly funded community support services.[4]

16 To allow for additional oversight, the Act requires all public mental health services to provide a report to the MHCC about complaints made directly to their service at the intervals specified by the MHCC.

17 The key roles and responsibilities of the MHCC can be grouped into four key areas:

(a) safeguarding the rights and dignity of individuals, families and carers;

(b) resolving complaints in ways that uphold people's rights and supports their recovery;

(c) supporting services to develop effective complaint resolution processes; and

(d) using information from complaints to address issues of rights, quality and safety and to achieve service and systemic improvements.

18 Under the Act, the MHCC's role in relation to these areas is inter-related. It is important to recognise that complaints represent the lived experience of consumers, families and carers. Complaints highlight key issues of rights, quality and safety in services.

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[3] For a full list of the persons and bodies to whom the Commissioner can make recommendations and provide information, see *Mental Health Act* s 228(j).

[4] See the definition of "mental health service provider" in *Mental Health Act* s 3(1). The list of Designated Mental Health Services is set out in *Mental Health Regulations 2014* (Vic) sch 1. The MHCC's powers after accepting a complaint are set out in s 243(4).

Ensuring high-quality and safe mental health services

19 Significantly, 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]

20 The MHCC also has broad functions to provide advice to service providers on any matters relating to complaints.[6] To this end, the MHCC makes recommendations arising from individual complaints and investigations, to drive improvements within individual services. Where we observe trends in complaints that indicate that systemic improvement is required, the MHCC makes systemic recommendations to the Secretary of the Department of Health and Human Services (**DHHS**) and the Chief Psychiatrist, as well as undertaking strategic projects such as the sexual safety project, which resulted in *The Right to Be Safe* report.[7]

21 These systemic recommendations and projects enable us to share the lessons learned through complaints and investigations, and our analysis of complaints data and themes, with the DHHS and services in order to drive broader service and system improvements. We also report on systemic recommendations publicly. A summary of the recommendations made to the Secretary of the DHHS and the Chief Psychiatrist under s 228(j) of the Act on specific issues of quality, safety and rights identified in complaints and investigations appears in Appendix B of the MHCC's submission to the Royal Commission (**Submission**).[8]

Receiving and resolving complaints

22 The MHCC was established in response to the extensive community consultations and legislative review processes that preceded the Act.[9] 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."[10]

23 The approaches taken by the MHCC were developed through extensive input and consultations with consumers, families, carers and services. Our approaches continue to evolve, informed by feedback and input from consumers, families, carers and services

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[5] *Mental Health Act* s 228(j).
[6] *Mental Health Act* s 228(e).
[7] Mental Health Complaints Commissioner, *The Right to Be Safe* (2018). For a summary of findings, see Mental Health Complaints Commissioner, 'Summary: The Right to Be Safe' <www.mhcc.vic.gov.au/Api/downloadmedia/%7BC87E6E9C-C6EB-4A45-9DFA-CE0F95C588D0%7D>.
[8] Submission (July 2019).
[9] Victoria, *Parliamentary Debates*, Legislative Assembly, 20 February 2014, 458–79.
[10] Victoria, *Parliamentary Debates*, Legislative Assembly, 20 February 2014, 473 (the Hon Mary Wooldridge MP).

(through our Advisory Council, sector engagement and feedback received by our office) as well as best practice approaches in complaint resolution. When the MHCC started operation in 2014, Victoria was the first and only Australian state to establish a specialist mental health complaints body. Since then, Victoria has recorded significantly more mental health complaints than any other jurisdiction. The MHCC's approach has also been highlighted by the Australian Commission on Safety and Quality in Health Care as an example of the advantages a specialist approach to mental health complaints brings, in providing an opportunity to learn more about the specific issues people experience when accessing mental health services, and what actions can be taken to address these.[11]

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

25 The MHCC works to resolve complaints in ways that:

(a) safeguard rights, by promoting awareness of people's rights, and compliance with the Act and the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (***Charter***);

(b) support recovery, by ensuring that people are heard and respected and feel confident that their views and preferences have been appropriately considered;

(c) improve services, by ensuring compliance with the Act and identifying opportunities to improve services;

(d) improve individual experiences, by providing a person-centred process that works to reduce fears and barriers to raising mental health complaints, and build the confidence and relationships needed for a person to raise concerns directly with the service; and

(e) aim to prevent a recurrence of issues, both for the individual concerned and for others.

26 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, the

[11] Australian Commission on Safety and Quality in Health Care, *Vital Signs 2017: The State of Safety and Quality in Australian Health Care* (2017) 32–5.

MHCC plays a vital role in improving people's experiences and supporting their journey towards recovery and wellbeing.

27 Where the MHCC is not the right body to help to resolve a person's concerns (for example because the issues raised are not within our jurisdiction or are more appropriately dealt with by another body), we seek to understand people's concerns so we can support them with the appropriate information or referral if we are unable to help with their complaint.

28 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.

Types of complaints received by the Mental Health Complaints Commissioner

29 A detailed overview of the types of complaints received by the MHCC is provided in each of the annual reports produced by the MHCC since its first year of operation in 2014–15. The MHCC's Submission also outlined the key themes identified in complaints over the MHCC's first five years of operation.

30 Under the Act, the MHCC can deal with complaints about public mental health services in Victoria.[12] The MHCC can deal with complaints about the following services:

(a) Designated Mental Health Services (including hospital-based, community, residential, specialist and forensic services);[13]

(b) publicly funded community support services, unless they are funded by the NDIS;[14] and

[12] *Mental Health Act* s 234.
[13] A Designated Mental Health Service is a service prescribed under s 3(1) of the *Health Services Act 1988* (Vic) or the Victorian Institute of Forensic Services: see definition of "designated mental health service", *Mental Health Act* s 3(1).
[14] The Act does not define publicly funded community support services, but they include the services formerly known as "Psychiatric Disability Rehabilitation and Support Services", which were provided by non-government organisations.

(c) NDIS services, if the complaint relates to things that happened before 1 July 2019 or before the service was funded by the NDIS.[15]

31 The MHCC does not have jurisdiction to deal with complaints about private mental health services or private mental health practitioners. If received, these complaints are referred to the Health Complaints Commissioner (**HCC**). Both the HCC and the MHCC have processes to make notifications and referrals to the Australian Health Practitioner Regulation Agency (**AHPRA**), where complaints raise issues about the conduct or fitness to practice of an individual health practitioner (see paragraph 64 for a discussion about the MHCC's processes).

32 Since the first year of operation, consumers have made the majority of complaints (approximately 70%). Complaints from families and carers have made up a quarter of complaints received. The remainder are made by people like advocates or staff members making complaints on behalf of consumers, or other people expressing concerns about the nature of treatment and care that a mental health service is providing.

33 The most common issues in complaints fall under one of four broad categories: treatment, communication, staff conduct and behaviour, and medication. These issues are usually inter-related, and most complaints raise multiple issues about people's experiences with the mental health service. These themes have been reasonably consistent since the MHCC commenced operation in 2014.

34 The key point to make about the complaints that the MHCC receives is that they represent the concerns and adverse experiences of people accessing public mental health services. Complaints provide vital insights into the nature of people's experiences, and can identify key issues of quality, safety and rights in the provision of mental health services. A key feature of the MHCC's role and approach to complaints is to assess complaints through the "lens" of the rights, requirements and principles of the Act and the *Charter*.

35 An underlying theme in the complaints is that people do not feel at the centre of their treatment and care. This is at odds with the explicitly stated objectives of the Act when it was introduced to Parliament. People making complaints to our office are often deeply distressed and traumatised by their experiences. Families and carers also express deep levels of distress about their loved ones' experiences, including about issues of access to services, and the quality or nature of treatment and care provided. Families and carers are often also distressed about their own experiences, including the lack of effective communication with or inclusion of families and carers by services.

36 In the majority of complaints received by the MHCC, people want their individual concerns to be addressed and resolved, as well as wanting their complaint to make a difference for

[15] The NDIS Quality and Safeguards Commission now deals with all other complaints about NDIS services.

other people—they want to prevent a reoccurrence of a similar incident and to contribute to improving services for others. These are also the key messages about complaints that we have promoted as part of our education and engagement work.

Common quality and safety issues identified since commencing in the role as Mental Health Complaints Commissioner

Overall themes

37 Quality and safety issues are very much inter-connected and to a large extent reflect the culture and models of care within services. 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.

38 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.

39 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 (**EDs**). These issues are most commonly associated with breaches of people's safety and adverse events in acute inpatient environments, particularly in High Dependency Unit or Intensive Care Area environments, and the use of restrictive practices in inpatient environments and EDs.

Overview of issue types

40 The MHCC classifies issues in complaints using a taxonomy comprising approximately 200 distinct issues sorted into three main levels. Level 1 issues correspond to the standard categories in the Victorian Health Incident Management System (**VHIMS Central**), in order to allow for comparators between health services. However, these Level 1 issues are too broad to give us meaningful insights, so we have developed Level 2 and Level 3 to categorise issues more specifically. For example, a Level 1 issue is

"Treatment", and some related Level 2 issues are "Suboptimal Treatment" and "Restrictive Interventions".

41 Level 3 issues are more specific again, and generally correspond to principles or objectives of the Act, or issues relating to specific policy, practice or administration issues. For example, related to the Level 2 issue of "Suboptimal Treatment" is the Level 3 issue of "Needs not met – physical health". This Level 3 issue corresponds to the mental health principle, as stated in the Act, that persons receiving mental health services should have their medical needs recognised and responded to.[16] Level 3 issues also enable us to capture detailed information about:

(a) whether specific Act requirements were met (eg the Level 3 issue that describes whether requirements for the use of restrictive interventions were met, 'inadequate authorisation for use…' is captured under the Level 1 issue of 'treatment' and the Level 2 issue of 'restrictive interventions');

(b) specific practice or safety issues (eg the Level 3 issue of 'unsafe or premature discharge' is captured under the Level 1 issue of 'treatment' and the Level 2 issue of 'inappropriate discharge or transfer'); and

(c) system management issues (eg concerns about quality of food or emails are captured in the Level 1 issue of 'facilities', the Level 2 issue of 'accommodation', and the detailed Level 3 issue of 'quality of food or meals').

42 We have collated the complaints data for the period of 1 July 2014 to 30 June 2019 to provide numbers and percentages of specific quality and safety issues identified in complaints over the first five years of the MHCC's operation.

43 Below, I describe some of the Level 2 and Level 3 issues. I address them under the following headings: treatment; communication; staff conduct and behaviour; and other specific issues. More information about the themes described below is available in the MHCC's Submission and in the MHCC's annual reports.[17]

Issues about treatment

44 Common issues relating to the quality of services relate to people's experiences of treatment (raised in 4555 in-scope complaints, 64% of all in-scope complaints made between July 2014 and June 2019).

[16] See *Mental Health Act* s 11(1)(f).
[17] See Submission (July 2019) 23–51, Appendix A.

45 Most commonly over the nearly six years of the MHCC's operation, these have included concerns about the extent to which people feel they have been meaningfully involved in their treatment, and the extent to which treatment has responded to their needs.

46 These concerns include the following Level 3 issues:

(a) inadequate consideration of the views and preferences of consumers (raised in 1208 in-scope complaints, 17% of all in-scope complaints made between July 2014 and June 2019);

(b) disagreement with Temporary Treatment Order (raised in 778 complaints, 11% of all complaints);[18]

(c) inadequate consideration of the views of families or carers (681 complaints, 10% of all complaints); and

(d) lack of care or attention (444 complaints, 6% of all complaints).

47 Other Level 3 issues raised that reflect quality of treatment have included:

(a) failure to meet consumers' physical health needs (210 complaints, 3% of all complaints);

(b) inadequate treatment planning (218 complaints, 3% of all complaints); and

(c) inadequate therapeutic options (148 complaints, 2% of all complaints).

Issues about communication

48 Common issues about the quality of mental health services relate to communication (raised in 2043 in-scope complaints, 29% of all in-scope complaints made between July 2014 and June 2019).

49 Complaints about communication have involved the Level 3 issues of: the provision of inadequate, incomplete or confusing information (1023 complaints, 14% of all complaints); and inadequate communication with families or carers (300 complaints, 4% of all complaints).

[18] Most complaints that involve disagreement with a Temporary Treatment Order involve multiple issues, including the consumer feeling their views and preferences have not been considered. Where concerns are solely about compulsory status, we support the person to understand their rights and contact the Mental Health Tribunal, as the most appropriate body to help with their concerns. In 2018-19, there were 37 complaints where we assessed that there was a more appropriate body to deal with the person's concern.

Issues about conduct and behaviour

50 Common issues relating to the safety of mental health services relate to the conduct and behaviour of staff and consumers (raised in 1375 in-scope complaints, 19% of all in-scope complaints made between July 2014 and June 2019).

51 These complaints have involved Level 2 issues including:

(a) alleged threats, bullying or harassment by staff (176 complaints, 2% of all complaints);

(b) alleged threats, bullying or harassment by consumers or others (119 complaints, 2% of all complaints);

(c) alleged physical assault by staff (119 complaints, 2% of all complaints);

(d) alleged physical assault by consumers or others (82 complaints, 1% of all complaints);

(e) alleged sexual misconduct by consumers or others (71 complaints, 1% of all complaints); and

(f) alleged sexual misconduct by staff (64 complaints, 1% of all complaints).

Other specific issues

52 Other specific quality and safety issues include:

(a) the use of restrictive interventions (a Level 2 issue), including the Level 3 issues of mechanical and physical restraint, and seclusion (266 complaints, 4% of all complaints);[19]

(b) adverse outcomes (a Level 2 issue), including the Level 3 issues of death or suicide, physical or psychological injury, self-harm or attempted suicide, and unexpected complications (129 complaints, 2% of all complaints);

(c) non-gender-safe environments (a Level 3 issue) (46 complaints, 1% of all complaints); and

(d) generally unsafe environments (a Level 3 issue) (60 complaints, 1% of all complaints).

Specific themes in quality and safety issues identified in complaints

53 In the MHCC's Submission, we outlined a range of specific types of quality and safety issues identified in complaints that relate to different settings and aspects of treatment:

[19] For more information, see paragraph [216].

(a) access to services and crisis responses;

(b) access to and treatment in EDs;

(c) use of restrictive interventions;

(d) rights, autonomy and choice in treatment and supports;

(e) least restrictive treatment;

(f) trauma-informed care;

(g) sexual safety in acute inpatient units;

(h) quality and safety and avoidable harms;

(i) needs related to physical health, disability, and alcohol and other drugs;

(j) holistic, inclusive, and recovery-oriented treatment; and

(k) service linkages and pathways.

54 In our Submission, we provided examples under these headings.[20] The examples provide important insights into these quality and safety issues in mental health services.

Mechanisms and processes for handling complaints about service quality and safety

Complaints mechanisms of mental health services

55 Section 266 of the Act requires mental health service providers to establish procedures for receiving, managing and resolving complaints about the provision of mental health services.

56 Under s 267 of the Act, mental health service providers are required to provide reports on the complaints received by their service. Prior to amendments made in October 2019, the legislation required services to provide biannual reports and specified that these reports included the number and outcomes of complaints. This section was amended so that service providers would have to provide reports at "intervals specified by the Commissioner",[21] that contain "information required by the Commissioner".[22]

57 Mental health services have responded positively to requests for further details on complaints data. For instance, the MHCC's sexual safety project asked services to provide more information on complaints they received about sexual safety breaches. Whilst the MHCC has received positive responses to its requests, it still welcomes the amendments made in October 2019, because they provide greater scope for the MHCC

[20] Submission (July 2019) 25–52.
[21] *Mental Health Act* s 267(1).
[22] *Mental Health Act* s 267(2)(b).

to seek information on specific quality and safety issues, and to identify emerging trends and areas requiring greater examination.

58 Trends in the numbers of complaints made to mental health services vary significantly. Some services have low numbers of complaints made directly to the service and higher numbers to the MHCC. This pattern may indicate that the complaints mechanisms at these services are not effective, or that complaints are not well understood, recorded or responded to. Conversely, high numbers of complaints made to the services combined with low numbers of complaints to the MHCC may indicate that the service has a positive complaints culture where complaints are well-recognised, recorded, and responded to adequately. The local complaints reports provided to the Royal Commission outline the numbers of complaints made directly to each service and reported to the MHCC, compared with the numbers of complaints made to the MHCC about each service.

Other complaints mechanisms and referral processes

59 The MHCC is the only external specialist complaints body with powers to deal with complaints about public mental health services. Under the Act, the MHCC can deal with complaints that are raised by a consumer, by a person "acting at the request of a consumer", or by anyone who the MHCC is satisfied "has a genuine interest in the well-being of a consumer".[23]

60 The MHCC does not have powers to deal with "whistleblower" complaints unless there is a valid complaint relating to a consumer under the Act. Nor does the MHCC have "own-motion" powers to investigate quality and safety issues identified through the performance of its other functions. The MHCC does not have the jurisdiction to accept complaints about broader quality and safety issues or practices in mental health services where there is no identified consumer or consumers. There are also limitations on when the MHCC can deal with anonymous complaints.

61 Depending on the nature of the issue, these types of complaints are referred to the service, AHPRA, the Chief Psychiatrist, the Secretary of the DHHS, or the Community Visitors Program for consideration and follow-up.

62 Section 233 of the Act specifies that referrals from a range of nominated statutory bodies can be treated as complaints by the MHCC. These bodies are:

(a) the AHPRA;

(b) the Community Visitors Mental Health Board;

(c) the Chief Psychiatrist;

[23] *Mental Health Act* s 232.

(d) the Public Advocate;

(e) the HCC;

(f) the DSC;

(g) the Commission for Children and Young People;

(h) the Victorian Equal Opportunity and Human Rights Commissioner;

(i) the Information Commissioner;

(j) the Ombudsman; and

(k) the NDIS Commission.

63 This provision means that issues raised with these bodies can easily be referred to the MHCC. The MHCC has established referral practices and protocols to facilitate consultation and appropriate referrals with these other bodies.

64 If a complaint is made about the conduct or fitness to practice of an individual registered health practitioner, the MHCC makes a notification or referral to AHPRA, depending on the circumstances of the matter. The MHCC only has jurisdiction to accept complaints about services, not individual practitioners. Recent amendments to the Act have explicitly provided for information sharing with AHPRA.[24] The purpose of these new powers is to facilitate consultations, notifications and referrals between the MHCC and AHPRA. This is in line with the recommendations of DHHS's report, *Targeting Zero: Supporting the Victorian Hospital System to Eliminate Avoidable Harm and Strengthen Quality of Care* (2016) (***Targeting Zero* report**).

65 Under s 242 of the Act, the MHCC may also refer a complaint, part of a complaint or any matter arising from a complaint, to another body, organisation, agency or entity either with the consumer's consent, or without the consumer's consent if I am satisfied it is in the public interest to refer the complaint. My office makes referrals to agencies including the HCC, AHPRA, the Chief Psychiatrist, the Secretary of the DHHS, the Public Advocate, Community Visitors Program, the Mental Health Tribunal, the DSC, Victoria Police, the NDIA, and the NDIS Quality and Safeguards Commission. These referrals are made in circumstances where:

(a) the MHCC does not have jurisdiction to deal with the complaint or the particular issue identified;

(b) it is assessed that the matter is more appropriately dealt with by the other body; or

[24] *Mental Health Act* s 265(1A); see also the new s 242A about referrals to AHPRA.

(c) it is assessed that the quality and safety issues identified in the complaint should also be considered by the other body through the performance of their particular role and function.[25]

66 The MHCC also supports consumers to access other appropriate services including through warm referrals to agencies such as Independent Mental Health Advocacy (**IMHA**), Victorian Mental Illness Awareness Council (**VMIAC**), and Tandem, where the purpose of their contact with our office is more about seeking advocacy or support, than making a complaint. The MHCC's approach reflects the principle of "no wrong door" for people raising concerns with our office, whereby people are supported with the appropriate information or referral if we are unable to deal with their complaint.

Complaints about the MHCC

67 The MHCC responds directly to any concerns and complaints raised about people's experience with the MHCC through our internal complaints process. The MHCC also advises people of external complaints mechanisms to deal with their concerns.

68 The following bodies can deal with complaints about the MHCC:

(a) the Victorian Ombudsman (complaints about how the MHCC has handled a complaint or other process);

(b) the Commissioner for Privacy and Data Protection (complaints about the handling of personal information and certain actions taken under the *Freedom of Information Act 1982* (Vic));

(c) the HCC (complaints about the handling of health information); and

(d) the Victorian Equal Opportunity and Human Rights Commission or VCAT (complaints about alleged discrimination).

Objectives of the Mental Health Complaints Commissioner

Achievement of objectives

69 From its first year of operation, the MHCC has demonstrated the value of a specialist approach to mental health complaints. The annual number of enquiries and complaints made to the MHCC has increased each year since 2014, rising from 1456 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

[25] Examples of referrals made in these circumstances are referrals to the Chief Psychiatrist of issues relevant to his role of providing clinical leadership, and referrals to the Community Visitors Program to follow up issues raised about particular facilities.

the number of complaints about public mental health services that are received by health complaints bodies in other jurisdictions in Australia.[26] 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 4% of people who are dissatisfied about a service will make a complaint.[27]

70 The MHCC has also demonstrated how the information gained through complaints can be used to drive improvements in the safety and quality of services, by making recommendations for service improvement in individual matters, as well as recommendations to address broader service improvement and systemic issues.

71 The MHCC's annual reports 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. From 1 July 2014 to 30 June 2019, the MHCC has made:

(a) over 200 recommendations directly to mental health services (in addition to over 400 service improvement initiatives by services in response to complaints. These improvements include changes that are identified through the service, the consumer and the MHCC working together to resolve the complaint, improvements made in response to a recommendation, and improvements identified proactively by the service after receiving the complaint);

(b) 10 recommendations to the Chief Psychiatrist from *The Right to Be Safe* report relating to sexual safety;[28] and

(c) 32 systemic recommendations to the Secretary of the DHHS (including the overall recommendation and 15 specific recommendations from *The Right to Be Safe* report).

72 The recommendations to the Secretary of the DHHS cover areas including sexual safety, discharge planning, restrictive interventions, responding to the needs of people with dual disability, compliance with the requirements of the Act for making Assessment Orders,

[26] See, eg, *Health Care Complaints Commissioner NSW Annual Report 2017–18* (2018) 19–20, 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* (2018), which records 349 mental health complaints including complaints about private providers.
[27] See the discussion of this research in Disability Services Commissioner, *Good Practice Guide and Self Audit Tool* (2nd ed, 2013) 18–19.
[28] Mental Health Complaints Commissioner, *The Right to Be Safe* (2018).

infrastructure issues, and reporting protocols for Victoria Police regarding allegations of assault within mental health services.[29]

73 Over the past two years, service improvement activities have also included legal undertakings by services to take remedial actions to address issues of compliance with the requirements and principles of the Act.[30] These undertakings enable our office to formally monitor and assess the service improvement actions taken by services.

74 In addition to the above indicators of success, the MHCC has also demonstrated the value of local complaint reporting by services, through the production of comparative complaints data reports (both sector-wide and individual service provider level analysis), and the effectiveness of our education and engagement functions with consumers, families, carers and services in changing people's thinking and approach to complaints. We emphasise that complaints are about people's experiences of mental health services, with the key messages of "Speak up. Your experience matters" and "Speaking up improves services for you and other people".

75 The value of having an independent, specialist body is also demonstrated by our individualised approach to complaints, the number of complaints reported to us, and the number of recommendations and service improvements made over the nearly six years of our existence. These factors indicate that an independent, specialised body can resolve complaints about people's experiences in mental health services and support improvement in the quality and safety of mental health services.

Factors critical to achievement of objectives

76 The overarching factor that has been critical to the achievement of the MHCC's objectives is that our approaches have been developed from extensive community consultations and continue to be driven by the lived experience of people accessing mental health services and those who have engaged with our office. We have always encouraged applications from people with lived experience for all roles within our office, in addition to having a dedicated lived experience position (Senior Adviser, Lived Experience and Education) and an Advisory Council that bring perspectives as consumers, carers and people working within services.[31] Our current Deputy Commissioner, Maggie Toko, is also recognised for her lived experience expertise, leadership and sector knowledge. Strong stakeholder engagement has been critical to achieving the objectives of supporting people to speak up about their experiences and to make improvements to services.

[29] The MHCC provided a full list of these recommendations in its Submission (July 2019) Appendix B.
[30] See discussion in MHCC Annual Report (2019) 13.
[31] See also paragraphs [162] and following.

77 It is significant that the community consultations on the reforms to the mental health legislation (from 2009 through to 2014) consistently identified the need for a specialist independent body to deal with mental health complaints.[32] In the year leading up to the establishment of the MHCC, there were extensive consultations with consumers, families, carers, services and other stakeholders to identify what would be most important in addressing the fear of, and barriers to, making a complaint and effectively responding to complaints.

78 The principles of the MHCC (accessible, supportive, accountable, collaborative and learning-focused) were developed on the basis of the feedback provided through these establishment consultations. The principles continue to guide our work. We are in the process of developing a sixth principle, "driven by lived experience", to reflect the fact that all of our work is informed and driven by lived experience—through both the experiences reported to us in complaints, and direct engagement with people with lived experience across all of our work. These principles are reflected in our approach to our work, particularly in the way we respond to complaints and conduct investigations into people's experiences in mental health services. We strive to be flexible in our approaches and to respond to people's individual needs and preferences by, for example:

(a) communicating with people in ways that suit them best (offering options of phone, face to face or email communication);

(b) being guided by the person about the time and space they need to feel comfortable to talk about their concerns or to consider service responses;

(c) always checking with people that we have understood them and reflected their concerns accurately;

(d) encouraging the involvement of support people or advocates; and

(e) offering people meaningful choice throughout the complaint resolution process.

79 It is the *Mental Health Act* that both establishes the office of the MHCC and provides for mental health services. The fact that both are addressed in the same piece of legislation is another critical factor in achieving the objectives of the MHCC. In this way, the situation of the MHCC is different from that of most other complaints bodies, each of which is established under its own piece of legislation. This means that the office of the MHCC shares the objectives and principles of the Act with mental health services and others with prescribed roles under the Act (such as the Secretary, the Chief Psychiatrist, the Mental Health Tribunal and Community Visitors). In our engagement with services, we often talk

[32] See Bronwen Merner et al, 'Mental Health Bill 2014' (Research Brief No 5, Parliamentary Library and Information Service, Parliament of Victoria, March 2014) <https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/13616-mh-bill-paper-master> 9–11.

about having a shared purpose, but different roles to play, in respect to the objectives and principles of the Act.

80 Services' engagement with the MHCC has been generally strong which reflects the fact of our shared purpose. Many services have sought our input and advice on approaches to complaints, including asking us to provide education sessions to staff. Experiences of achieving positive outcomes and resolution of complaints have been important in changing approaches to complaints. This is particularly true for outcomes achieved through processes such as facilitated meetings, in which a person's concerns can be heard and acknowledged by a service's senior staff. Increasingly, services are seeking meetings with the MHCC to discuss themes arising from complaints. In these meetings, services also seek to discuss the comparative data about complaints made directly to their service compared to complaints made to the MHCC.

81 The value of being a specialist body cannot be underestimated. As a specialist body, the MHCC has staff who understand deeply the challenges experienced by all parties and the context in which services are provided. The skill and compassion of our staff in dealing with distressing and complex situations are critical to the effectiveness of the MHCC. Complaint bodies from other jurisdictions seek advice from our office on the practice approaches we have developed. Such bodies often note the difficulties they have in responding to the types of complaints we deal with every day.

82 The value of the MHCC's role as a specialist mental health complaints body has been recently highlighted in the responses to the COVID-19 crisis. Since the outset of this crisis, the MHCC resolutions team has been responding to the mental health impacts of the COVID-19 crisis for mental health consumers and their families. There has been an increase in the level of distress and gravity of concerns expressed by callers seeking assistance from the MHCC, as well as complaints about the direct impacts of COVID-19 on mental health service provision, such as issues in accessing services, restrictions on visitors and leave from inpatient units, and the management of risks associated with COVID-19 to consumers. These complaints to the MHCC have provided a vital window into the emerging experiences of mental health consumers, families and carers during the COVID-19 crisis. The MHCC has been meeting weekly with OCP and departmental representatives to share these themes from calls and complaints to the MHCC, which have been used to progressively inform the Department's mental health COVID-19 responses.[33]

83 The COVID-19 crisis has also reinforced the importance of the MHCC's strong collaborative relationships with other bodies within the quality, safeguarding and broader

[33] See presentation on the MHCC's role in responding to COVID-19 impacts in a webinar hosted by the Australian National University on 30 April 2020 <https://rsph.anu.edu.au/files/20200430%20FINAL%20DRAFT%20SLIDES%20Roundtable.pdf>.

regulatory system for mental health services. These relationships have also been critical for the achievement of the MHCC's objectives. In developing and maintaining these relationships, we recognise that all agencies have slightly different roles to play in working to improve services. One of the MHCC's objectives is to be accessible and responsive to the diversity of people's lived experiences. The MHCC's strong engagement with VMIAC, Tandem and other consumer and carer organisations and groups, along with IMHA, continues to be critical for achieving this objective and has been important for sharing insights and responses to the mental health impacts of the COVID-19 crisis. Also important is the MHCC's targeted engagement with priority population groups such as Aboriginal and LGBTIQ+ Victorians, which we have also continued throughout the COVID-19 crisis through engaging with the work being done by VACCHO, Switchboard and Joy-FM to support the mental health and wellbeing of these communities.

Factors that have made it difficult to achieve objectives

84 For the first five years of operation, the MHCC's capacity to conduct investigations, undertake data analysis and strategic projects, and deliver education and engagement activities was limited by the base budget, which was modelled on a much lower number of complaints. As we have dealt with over four to five times more complaints than anticipated in the resource modelling, we have needed to prioritise resources to respond to the volume and complexity of these complaints and rely on additional amounts of fixed-term funding to be able to conduct strategic projects or expand investigation capacity. The MHCC has since increased its capacity, particularly in relation to investigations and data analytics, 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.[34]

85 Achieving cultural changes in approaches to service provision and complaints within services, has also been affected by the stresses and resource constraints experienced by mental health services that have been well documented in the Royal Commission's Interim Report. It is clear from the complaints that we receive that services are operating within a very stressed system. The level of strain can also impact on the services' capacity to respond to complaints in a meaningful and supportive way.

86 As we noted in our Submission, "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."[35] The cultural changes required include the development of "positive complaints cultures" in which people feel confident and

[34] Victorian Government, *Victorian Budget 2019–20, Service Delivery* (Budget Paper No 3) 51, 59. The MHCC received additional budget allocations of $1.2 million in 2019–20 and $1.3 million in 2020–21, to the MHCC's base budget of $2.878 million. From 2016–17 to 2018–19, the MHCC received additional fixed-term funding from the DHHS to respond to specific demands and conduct investigations.
[35] Submission (July 2019) 5.

supported to speak up about their concerns, and complaints are seen as an opportunity to improve services for everyone.

87 The way in which complaints are viewed and treated varies broadly between services and between individual staff within services. There are many examples of individuals within services who show leadership in their responses to complaints and use them as an opportunity to work collaboratively with consumers or support people to create positive change, both for the individual involved and for the broader service. However, in many instances the MHCC has had to work very hard with services to support them to identify and make changes in response to complaints. There is a clear need for the MHCC to continue to develop and provide education and resources designed to build the capacity of services to effectively respond to complaints and increase the local resolution of complaints.

88 In addition, the MHCC has observed gaps in knowledge and understanding of the principles and requirements of the Act within services. This has meant that our efforts in both our complaint handling and education functions have necessarily had to address these foundational requirements for addressing issues raised in complaints.

89 There were also constraints on the MHCC's ability to share information for quality and safety purposes with agencies such as AHPRA, the Safer Care Victoria (**SCV**), and the Victorian Agency for Health Information (**VAHI**). These constraints existed until express provisions for information sharing were included in amendments to the Act in October 2019, and consequential amendments to the *Mental Health Regulations 2014* (Vic) in February 2020. Subsequent to, and in accordance with, these amendments, the MHCC has provided individual service provider complaint reports to both SCV and VAHI, along with the Secretary of the DHHS and the Chief Psychiatrist. The MHCC will be exploring ways in which complaints data can be used together with other data sets managed by the DHHS, VAHI and SCV to support quality and service improvements.

Changes to the role of the Mental Health Complaints Commissioner since commencing in 2014

90 As I described above, the office of the MHCC was established on 1 July 2014 with the commencement of the Act. Feedback through the community consultation processes for the development of the Act identified a level of dissatisfaction with the previous arrangements for making complaints about mental health services.

91 Complaints were previously managed by either the Office of the Chief Psychiatrist or the Health Services Commissioner (which was replaced by the HCC in 2017). At that time, people reported that complaints pathways were complex and difficult to navigate, and that responses to complaints were not timely or responsive to the needs of people

experiencing mental health challenges. People also reported concerns about the perceived lack of independence of the Chief Psychiatrist responding to complaints while also having a role in supporting and providing clinical leadership to mental health services. Further, there were previously no statutory mechanisms to ensure complaints led to improvement in the safety and quality of mental health services. The establishment of the MHCC therefore introduced new ways and approaches to dealing with mental health complaints.

92 Since the MHCC commenced operation, we have continued to develop our approaches and how we perform our functions. The MHCC's jurisdiction in relation to dealing with complaints about mental health community support services has been changed to exclude NDIS-funded services provided from 1 July 2019, with associated amendments to provide for referrals to and from the NDIS Quality and Safeguards Commission.

93 Further amendments made to the Act in October 2019 clarified the use of conciliation and undertakings, and included enabling provisions for information sharing for quality and safety purposes.

94 From 1 July 2020, the role of the MHCC will change in so far as one person will hold the dual roles of Mental Health Complaints Commissioner and Disability Services Commissioner. The Victorian Government has advised that the two will continue as separate offices under separate pieces of legislation, noting that the DSC's jurisdiction has been reduced to services that are not funded by the NDIS. Apart from the transition of DSC functions to the NDIS Quality and Safeguards Commission, the reasons provided for this change include that MHCC and DSC share some similar functions and powers, and that both roles had been filled by one Commissioner for a period in 2018.[36] These reasons have not included any factors related to the MHCC's role or performance. The impact of this change on the MHCC's role will be dependent on the proportion of the Commissioner's time that is required to fulfil the requirements of the DSC role, the approach that is taken to the work of the MHCC, and any other consequential changes that may occur.

[36] In 2018, I was requested to fill the role of Acting Disability Services Commissioner due to unexpected extended leave of that Commissioner, and I held this position in conjunction with my role as Mental Health Complaints Commissioner for four months.

The impact of technological advances in service delivery and consumer engagement on my role

Impacts for mental health service delivery and complaints

95 We have not received any specific complaints that relate directly to the use of technological advancements, including telehealth (ie the provision of health care remotely through the use of telecommunications technology).

96 My office has contributed to the development of a certification framework and National Safety and Quality Digital Mental Health (**NSQDMH**) Standards undertaken by the Australian Commission on Safety and Quality in Health Care.

97 The MHCC's input to this consultation is that a certification framework and standards must include safeguards to protect consumers from unsafe and poor quality practices. Digital mental health services should be required to have clear and accessible complaints processes as well as people having access to an independent complaints body.

Impacts for the MHCC's engagement and accessibility

98 The MHCC has found that social media is an important tool to support engagement with consumers, carers, families and the broader sector, and has had an active social media presence since it commenced operating.

99 The MHCC currently manages Facebook, Twitter and LinkedIn social media pages, with over 3500 followers. We have recently added Instagram to increase engagement with younger people, who are tending to use this platform (along with Snapchat and TikTok, for example) more than the "traditional" social media platforms. Managing the need to maintain a social media presence does have an impact on resources. We aim to use social media strategically to build engagement with our priority audiences that may experience additional barriers to making a complaint, particularly young people, LGBTIQ+ communities and Aboriginal Victorians.

100 As well as enabling us to build awareness of our role and function and to engage with other organisations, social media is one way people make their first contact before making a complaint. It is another way of increasing the accessibility of our office and processes. Whilst this is currently a very small proportion of complaints, we envisage that this may increase in future.

101 The MHCC expects that in the future it will increasingly engage through other technological means, including for example live chat functions, particularly to engage with younger people.

Comparable roles similar to the Victorian Mental Health Complaints Commissioner in other jurisdictions and the advantages and disadvantages of different models

102 The role of the MHCC is unique to Victoria. There are no other similar specialist mental health complaints bodies in Australia or overseas. Mental health complaints in other states and territories are handled by Commissioners who have responsibilities for dealing with physical health complaints. In some cases, those Commissioners also have responsibilities for dealing with other types of complaints, such as complaints about disability services or community services.

103 There are clear advantages in dealing with mental health complaints through a body that is specialised and independent, like the MHCC. The advantages and features of the MHCC's model have been described above in relation to achievement of the MHCC's objectives and the factors critical to this success. These advantages are demonstrated by the number and outcomes of complaints, compared to other jurisdictions, and in the way in which the MHCC has been able to demonstrate the use of information from complaints to drive service and system improvements.[37]

104 As indicated above in the discussion about factors critical to success, the advantages of the MHCC's model have also been highlighted in responses to the impacts of the COVID-19 crisis. The MHCC has been in the unique position to quickly identify and respond to emerging concerns and issues raised by consumers, families and carers, and to share these in an agile way to inform the department's COVID-19 mental health response and guidance to services. As part of the Mental Health Commissioners group, which contributed to the National Mental Health and Wellbeing Pandemic Plan,[38] it was evident that other jurisdictions did not have the equivalent information from complaints and concerns being raised by consumers, families and carers about the COVID-19 impacts on mental health service provision.

105 The disadvantage of not providing a specialist and independent body to deal with mental health complaints is that it is much more difficult for other types of complaints bodies to provide accessible and supportive processes that can effectively respond to the needs and issues raised by consumers, families and carers about their experiences of treatment, and to address the known fears and barriers to making a complaint. Compared to the quantum of complaints to the MHCC and the immediacy of dealing with oral complaints, other complaints bodies are less able to quickly identify emerging issues in mental health

[37] For more on the MHCC's use of numerical data, see above at paragraphs [70]–[71].
[38] Australian Government, 'National Mental Health and Wellbeing Pandemic Response Plan', May 2020 <https://www.mentalhealthcommission.gov.au/Mental-Health-and-Wellbeing-Pandemic-Response-Plan>.

service provision, as demonstrated by the MHCC's responses and contributions during the COVID-19 crisis.[39]

Trends in regulatory approaches

Principles, characteristics and components of contemporary, best practice regulatory approaches to safety and quality in mental health service delivery

106 The regulatory approaches to safety and quality in mental health service delivery vary considerably across jurisdictions, and are largely reliant on broader regulatory frameworks for health and community services. The *Better Regulatory Practice Framework* (2018) from the DHHS provides a useful overview of risk-based regulatory approaches, and of what regulators should be thinking about in terms of risk assessment and regulatory tools.[40]

107 Consistent with risk-based regulatory approaches, our decisions to use the higher end of our statutory powers (ie investigations and undertakings) are informed by a range of factors, including our assessment of the gravity of the concerns or allegations and whether the complaint raises practice or systemic issues. We also work closely with other bodies which have intersecting regulatory and oversight functions, such as AHPRA, DHHS and the Chief Psychiatrist. We use our powers to consult and share information to inform effective decision-making and approaches in addressing risk and safety issues.

108 Overseas research into the effectiveness of regulatory approaches has also identified that the reputation and credibility of the regulator can be a key factor in achieving positive outcomes and compliance from regulatory actions.[41] This would suggest the importance of having both specialist knowledge and strong sector engagement for effective regulatory approaches to safety and quality in mental health service delivery.

Changes in regulatory approaches (in Australia and internationally) to safety and quality in mental health services

Developments and factors driving changes

109 There are many components to the quality and safeguarding framework for mental health services, with many significant developments in recent years. This framework consists of inter-related regulatory, oversight and quality improvement mechanisms.

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[39] No other complaints bodies contributed to the above plan referred to in footnote 38; see also above at paragraph [82] on the MHCC's contributions to COVID-19 responses.
[40] DHHS, *Better Regulatory Practice Framework* (2018) 11, 14.
[41] See resources and research on regulation at National Regulators Community of Practice, 'Regulators Community of Practice', Australia and New Zealand School of Government <https://www.anzsog.edu.au/communities/regulators>.

110 In Victoria, since 2014, there have been two key seminal drivers of development. The first was the introduction of the *Charter*, which was a key driver for reforms to the Act to strengthen the human rights framework and safeguarding functions of the legislation. The second was the 2016 *Targeting Zero* report, which focused attention on the need for proactive and integrated approaches to addressing avoidable harms and risks in health services, including mental health services.

111 There are other key reports exposing harms in health, mental health, aged and disability services.[42]

112 In light of these reports, the *Charter* and the *Targeting Zero* report, it is now recognised that regulatory and oversight frameworks require integrated approaches to:

(a) partnering with consumers and families;

(b) performance monitoring;

(c) incident reporting and management, review of adverse events or "sentinel events" (which are wholly preventable adverse patient safety events that result in serious harm or death), and Root Cause Analyses (**RCAs**);[43]

(d) worker registration and screening;

(e) complaints culture and mechanisms;

(f) open disclosure;

(g) data and information sharing; and

(h) accreditation and standards.[44]

113 There is also increasing recognition that a human rights approach needs to underpin regulatory and oversight frameworks, particularly to safeguard the rights of people accessing mental health and disability services.[45]

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[42] See, eg, DHHS, *Chief Psychiatrist's Audit of Inpatient Deaths 2011–2014* (2017); NSW Chief Psychiatrist, *Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness in NSW Health Facilities* (2017); A Groves et al, *The Oakden Report* (SA Health, 2017); Family and Community Development Committee, Parliament of Victoria, *Inquiry into Abuse in Disability Services* (2016); Australian Human Rights Commission, *A Future without Violence: Quality, Safeguarding and Oversight to Prevent and Address Violence against People with Disability in Institutional Settings* (June 2018). See also Coroners Court of Victoria, "Victorian Coroners' Recommendations on Issues Pertaining to Mental Ill Health" (Submission to the Royal Commission into Victoria's Mental Health System, 1 July 2019).

[43] A health service may be required to conduct an RCA in response to types of critical incidents and sentinel events.

[44] Note, however, that there is general recognition that there has been an over-reliance on accreditation as an oversight and safeguarding mechanism. See further discussion below at paragraph [119].

[45] See Australian Human Rights Commission, *A Future without Violence: Quality, Safeguarding and Oversight to Prevent and Address Violence against People with Disability in Institutional Settings* (June 2018) 37.

114 The recommendations from the *Targeting Zero* report are being progressively implemented. Among the recommendations was the establishment of SCV and VAHI. The *Targeting Zero* report outlined the need for improvements in data analysis and sharing data between oversight agencies. The *Targeting Zero* report also informed the establishment of the Health Regulatory Intelligence Sharing Committee (**H-RISC**), which was initiated by AHPRA to improve the sharing of regulatory intelligence between health regulators, statutory authorities, administrative offices, and DHHS. The MHCC has participated as a member of the H-RISC.

115 SCV and VAHI are leading various pieces of work that directly deal with safety and quality in mental health services. These include:

(a) reporting requirements and guidance for the new "sentinel events" category (led by SCV);

(b) the Mental Health Clinical Network (led by SCV), including the Insight Subcommittee (for data sharing and analysis), of which the MHCC is a member;

(c) development of clinical guidance for *Caring for People Displaying Acute Behavioural Disturbance in Emergency Settings* (led by the SCV's Emergency Care Clinical Network);[46] and

(d) VAHI's *Inspire* reports, which include data on specified quality and safety indicators in mental health services.

116 In terms of overall developments and trends in regulatory approaches, it is evident that regulators like AHPRA are applying a more risk-based approach to regulation. This approach can mean that complaints about the manner in which a person was treated by a health practitioner may not reach the threshold for investigation or regulatory action. AHPRA has eight regulatory principles to guide decision-making, including to "identify and respond to risk" and "use appropriate regulatory force" to protect the public. The focus is on protecting future patients from harm from an unsafe practitioner.[47] The consequence may be that there is a different regulatory outcome for two practitioners who have done the same thing depending on what actions may have been taken to mitigate potential future harm and their risk profile.[48]

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[46] Safer Care Victoria, *Caring for People Displaying Acute Behavioural Disturbance* (Draft consultation paper, February 2020).
[47] AHPRA, 'Find out about the notifications process' (Video, 29 March 2019) <https://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process.aspx>.
[48] AHPRA has indicated that it is seeking to identify indicators of risk as part of a framework for continuing professional assurance: AHPRA, *Annual Report 2018/19* (2019) 19.

Standards and other developments

117 The second edition of the National Safety and Quality Health Service Standards (**NSQHSS**) includes a "Comprehensive Care Standard" which has requirements for "minimising patient harm". These new requirements have particular application and relevance for mental health services. The requirements include:

(a) predicting, preventing and managing self-harm and suicide (Action 5.31); and

(b) predicting, preventing and managing aggression and violence (Action 5.33).[49]

118 The Australian Commission for Quality and Safety in Health Care (**ACQSHC**) has also produced a user guide to help services implement the NSQHSS Standards.[50]

119 There is, however, a shift away from accreditation as a significant tool for monitoring quality and safety.[51] The Chief Psychiatrist of New South Wales has written a report on this topic, *Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness in NSW Health Facilities*.[52] This report referred to changing approaches to patient safety and the view that "there must be a move away from excessive reliance on regulation, accreditation and compliance to the promotion and encouragement of innovative thinking at a local level."[53]

120 The NDIS Quality and Safeguarding Framework and the creation of the NDIS Quality and Safeguards Commission is a further development in regulatory approaches to the provision of services to people receiving psychosocial support services funded by the NDIS.

121 The regulatory landscape is also influenced by how legal rights are interpreted by the courts, especially in Victoria with the introduction of the *Charter*. This is highlighted by the landmark Victorian Supreme Court decision in *PBU v Mental Health Tribunal*.[54] This case considered the human rights ramifications of the evaluation of whether a person had capacity to consent to electroconvulsive therapy (**ECT**). Professor Ian Freckleton QC has said that the judgement "utilises human rights principles which are fundamental to the balance that contemporary mental health legislation seeks to achieve…to require strict

[49] See ACQSHC, 'Comprehensive Care Standard' <https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard>.
[50] ACQSHC, *National Safety and Quality Health Service Standards: User Guide for Health Services Providing Care for People with Mental Health Issues* (2018).
[51] See, eg, DHHS, *Targeting Zero* (2016) 77–82.
[52] See also NSW Chief Psychiatrist, *Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness in NSW Health Facilities* (December 2017).
[53] NSW Chief Psychiatrist, *Review of Seclusion, Restraint and Observation of Consumers with a Mental Illness in NSW Health Facilities* (December 2017) 17, citing Chris Ham, "Reforming the NHS from Within: Beyond Hierarchy, Inspection and Markets" (The King's Fund, 2014).
[54] (2019) 56 VR 141.

and intellectually rigorous interpretation of powers to coerce treatment".[55] The judgement has clear implications for regulators and review bodies such at the Mental Health Tribunal and VCAT to take a strict and human-rights compliant approach to interpreting powers.

Future evolution of regulatory frameworks

122 Lived experience perspectives must be central to the development of improved safety and quality indicators. This is important because it will help us focus on the issues that consumers, families and carers see as most important. These issues may be different from the kinds of issues that are currently measured and may include, for example:

(a) a specific focus on reporting matters that impact on people's human rights, including the use and duration of compulsory treatment and more detailed reporting about the use and duration of restrictive interventions;

(b) public reporting of alleged physical or sexual assaults occurring in mental health services;

(c) developing measures about the extent to which people feel their views were respected and supported during their treatment; and

(d) developing measures about the extent to which mental health services seek to engage and work with families and carers.[56]

123 The MHCC has also highlighted the need to consider the implications of Australia's ratification and implementation of the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (**OPCAT**).[57] It is necessary to consider the way the ratification of OPCAT creates both an increased obligation and an 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. This is particularly relevant for treatment administered in closed environments and for the use of restraint or seclusion.[58]

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[55] Ian Freckleton, *Electroconvulsive Therapy, Law and Human Rights: PBU & NJE v Mental Health Tribunal [2018] VSC 564, Bell J* (2019) 26(1) *Psychiatry, Psychology and Law* 1, 17.

[56] Submission (July 2019) 15. It is also noted that significant work has been undertaken by DHHS to develop a performance and accountability framework, with planned additional measures of consumer and carers' experiences with services.

[57] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 4 February 2003, 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.

[58] See also the discussion in Mental Health Complaints Commissioner, *The Right to Be Safe* (2018) 24. See also Lynne Coulson Barr, 'Australian Perspectives on OPCAT' (Speech delivered at Towards Eliminating Restrictive Practices: Twelfth National Forum, Hobart, 8 November 2018) <http://www.terpforum.com/wp-content/uploads/2018/11/1430-COULSONBARR-Thursday.pdf>.

124 In the future, regulatory approaches are also likely to have an increasing focus on the importance of service cultures for ensuring safety and quality. Mental health services need to develop cultures that:

(a) understand and prioritise physical, psychological, emotional, spiritual and cultural safety;

(b) know that this means supporting people to understand and exercise their rights, and have choices about their treatment; and

(c) understand that this means implementing systems and approaches that will reduce or eliminate the use of restrictive interventions and other forms of coercion.

Best practice examples of innovative approaches to regulating the quality and safety of mental health service delivery

125 As I indicated above, approaches to quality and safety in mental health service delivery (and more broadly in health) are increasingly emphasising the critical importance of partnering with consumers in all aspects of care. The importance of this is highlighted in the NSQHS (Standard 2: Partnering with Consumers). This Standard requires "[c]linical governance and quality improvement systems to support partnering with consumers".[59] This is also reflected in the guidance developed by SCV for partnering with consumers,[60] and existing approaches used by both the MHCC and the Chief Psychiatrist to include lived experience expertise in the conduct of reviews and investigations into quality and safety issues in mental health services.

126 In *The Right to Be Safe* report, the MHCC made recommendations to address the issues of sexual safety in acute mental health inpatient units. The MHCC's approach in formulating these recommendations is a best practice example of addressing a critical issue in mental health service delivery. The approach is arguably broader than a regulatory approach. The approach applied a human rights and violence prevention framework to formulate recommendations to address the critical risks to consumers' sexual safety in these environments.

127 This framework defines three levels of interventions.[61] Among the primary prevention interventions are the whole-of-population initiatives that address the underlying drivers of sexual safety breaches (in this instance, taking a "whole of system" approach). Secondary interventions are targeted prevention strategies that aim to identify and respond to

[59] ACSQHC, 'Partnering with Consumers Standard' <https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard>.
[60] Safer Care Victoria, 'Partnering in Healthcare', Better Safer Care <https://www.bettersafercare.vic.gov.au/resources/tools/partnering-in-healthcare>.
[61] Mental Health Complaints Commissioner, *The Right to Be Safe* (2018) 30.

individuals who are at a 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.

128 In this project, the MHCC's approach also reflected the recommendations in the *Targeting Zero* report, and included the following components:

(a) an analysis of complaints to the MHCC and those reported directly by services ("local complaints");

(b) findings of the four investigations that the MHCC completed in 2017–18 relating to breaches of sexual safety;

(c) a review of literature, research, policies, standards and initiatives; and

(d) consultations with key stakeholders and people with relevant experience and expertise.

129 Most importantly, the approach taken in *The Right to Be Safe* report was to ensure that the findings and recommendations reflected the direct lived experience of consumers who had raised their concerns about their experiences with the MHCC and with services. We were also guided by a project reference group of members with lived experience and expertise in issues of sexual safety in mental health services.

Independent oversight

Existing independent oversight mechanisms in the mental health system

130 There are a number of oversight bodies that have a role in responding to issues relating to mental health services. Together these bodies form a quality and safeguarding framework for mental health services in Victoria. All of these agencies have a different focus and purpose. To the extent that there is a potential overlap, the MHCC has processes and arrangements to minimise duplication of roles and promote collaborative approaches. We have continued to refine and develop these over time, in line with the *Targeting Zero* report recommendations and 2019 legislative amendments which support information-sharing for quality and safety purposes.

131 As part of the MHCC's Governance Meetings with DHHS, we have put forward the benefits of formally mapping the quality and safeguarding framework for mental health services in Victoria by setting out the respective roles and responsibilities of all of the different bodies and their inter-relationships. The Victorian Auditor General's 2019 report on Child and Youth Mental Health[62] included a framework for monitoring and oversight mechanisms for these services that was provided by DHHS, but this did not include the

[62] Victorian Auditor General's Office, *Child and Youth Mental Health June 2019: Independent assurance report to Parliament 2018–19*: 26; p 44.

MHCC or any of the oversight bodies that I describe below. DHHS has agreed to the benefits of mapping out this current framework.

132 The Terms of Reference for the MHCC/DHSS Governance Meetings include:

(a) a formal mechanism for acquitting recommendations made by the Mental Health Complaints Commissioner under s 228(j) of the *Mental Health Act*;

(b) an information sharing forum for discussion about emerging themes/issues identified from complaints and education activities by the MHCC and potential recommendations, themes from contacts to the Minister, DHHS and OCP, and relevant policy and program developments from DHHS/OCP, including workforce development and training, a review of the *Mental Health Act* and proposed legislative amendments to the NDIS;

(c) a mechanism for coordinating work and initiatives and reporting on quality and safety issues between MHCC, OCP, Safer Care Victoria and VAHI, including the Clinical Mental Health Network; and

(d) an opportunity for engagement on any other matters, including opportunities for collaboration between DHHS/OCP and the MHCC.[63]

133 The above MHCC/DHSS Governance Meetings were established in early 2019. Previously, there has been a range of different meetings established with DHHS with the aim of co-ordination and collaboration on issues of oversight and quality and safety in services. These included "Quality and Safety Meetings" in 2017 between the Director of Mental Health Branch, OCP, MHCC, Safer Care Victoria and VAHI. In 2015, the MHCC was invited by DHHS to be part of an 'oversight committee' with other independent bodies and agencies such as the Mental Health Tribunal, the Public Advocate/Community Visitors Program and IMHA, to share insights on the implementation of the *Mental Health Act* and the operation of its safeguards. Following the restructure of DHHS in 2015, this committee did not eventuate. The MHCC has however continued to work closely with the other key oversight bodies and agencies to share insights and promote collaborative approaches, as outlined below.

<u>Key oversight mechanisms and relationships with the MHCC</u>

134 Below, I describe seven of the key oversight bodies or agencies that operate in Victoria. First, there is the Chief Psychiatrist. The role and functions of the Chief Psychiatrist are set out in the Act.[64] There is potential overlap in the matters that can be investigated by the MHCC and the Chief Psychiatrist. The MHCC and the Chief Psychiatrist regularly

[63] *Quarterly meetings between Department of Health and Human Services and Mental Health Complaints Commissioner-Terms of Reference*, January 2019.
[64] *Mental Health Act* ss 120–1.

consult about matters that our respective offices are dealing with. We do this in order to minimise duplication, ensure alignment of purpose and share information about arising issues. It is appropriate that the MHCC and the Chief Psychiatrist each has the power to conduct investigations as outlined in the Act. Both offices have safeguarding, oversight and service improvement functions, which cannot meaningfully be fulfilled without the power to conduct investigations and hold services accountable for their actions and decisions. The MHCC has the power to conduct an investigation into a complaint,[65] or at the request of the Minister, "can investigate into, and report on, any matter relating to mental health service providers".[66] Under the Act, the Chief Psychiatrist can "conduct investigations in relation to the provision of mental health service providers",[67] which aligns to the Chief Psychiatrist's system-wide roles of providing clinical leadership and expert clinical advice, improving quality and safety, and promoting the rights of persons receiving mental health services. The investigations conducted by the MHCC and by the Chief Psychiatrist are complementary and both include a focus on rights and the requirements of the Act, and service improvement. The MHCC's investigations are however distinguished from the types of broader "quality and safety" investigations conducted by the Chief Psychiatrist, in that the MHCC is required to make findings on "the substance of a complaint", "decide on any actions to be taken to resolve the complaint", and prepare a written report which is provided to the service, the consumer, and the person who made the complaint (if that person is not the consumer and if the provision of the report would not unreasonably breach the privacy of the consumer).[68] The Commissioner may also provide a copy of the investigation report, if assessed as appropriate, to the Minister, Secretary or the Chief Psychiatrist.[69] A de-identified copy of the report of every investigation conducted by the MHCC has been provided the Secretary and the Chief Psychiatrist, together with recommendations for systemic improvement which have been identified through the investigations.

135 Secondly, there is the HCC. The HCC deals with complaints about health services. There is potentially an overlap in the jurisdiction of the MHCC and HCC in some cases, for example, in relation to complaints about EDs where they relate to mental health services. The MHCC and the HCC have arrangements in place to consult about these complaints and decide whether a referral to the other agency is appropriate.

136 Thirdly, there is AHPRA. AHPRA regulates individual clinicians who are registered practitioners under the National Law. As a "health complaints entity" under the National Law, the MHCC is required to notify AHPRA when we receive a complaint about a registered practitioner and come to an agreement about which agency should take action.

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[65] *Mental Health Act* s 243(4)(c).
[66] *Mental Health Act* s 228(k).
[67] *Mental Health Act* s 121(i).
[68] *Mental Health Act* ss 257(1)–(3).
[69] *Mental Health Act* s 257(4).

It is appropriate that concerns about the conduct, behaviour and fitness to practice of individual clinicians are managed by a separate oversight body which has existing structures and processes in place to support an assessment of whether the conduct or practice of individual clinicians meets acceptable professional standards. Further, as discussed above, AHPRA's mandate is to assess future risk to the public from individual practitioners, and AHPRA does not have a role in dispute resolution or seeking outcomes that respond to the person's individual experience or concerns.

137 Fourthly, there is the Mental Health Tribunal. The MHCC will not deal with a complaint that relates to a decision on whether the person should be subject to a compulsory Treatment Order if this is within the jurisdiction of the Mental Health Tribunal.

138 Fifthly, there is the Public Advocate and the Community Visitors program. The Public Advocate is appointed under the *Guardianship and Administration Act 2019* (Vic) to promote and safeguard the rights and interests of people with disability. Community Visitors are independent volunteers who safeguard the rights of people with disability, including psychosocial disability, by visiting people with disability at the services they reside in, engaging with them directly, working to resolve problems and referring serious matters within the Office of the Public Advocate or to other bodies including the MHCC, to be dealt with under the powers of that body. The Community Visitors program has three streams—Disability Services, Mental Health and Residential Services. Each of these is supported and governed by a Board established under relevant legislation for that sector.[70] The boards form the combined Community Visitors Board, which is chaired by the Public Advocate.

139 The MHCC can receive referrals from the Public Advocate and the Community Visitors Board, and also makes referrals to community visitors to follow up particular issues in units that may have been identified in complaints, such as the availability of activities and amenity of facilities.

140 Sixthly, there is the Coroners Court. If the MHCC receives a complaint relating to the death of a person that is the subject of a coronial investigation, the MHCC will not deal with issues relating to the cause of death until after the conclusion of the coronial process. The MHCC may then review the coronial decision to identify whether there are any issues that arise from the decision or the circumstances of the case that are appropriate for the MHCC to deal with.

141 Finally, in respect to other independent bodies and statutory processes, there are the police and legal proceedings. The MHCC will not deal with a complaint if we are aware

[70] *Disability Act 2006* (Vic); *Mental Health Act*; *Supported Residential Services (Private Proprietors) Act 2010* (Vic).

that police are taking action in relation to the same matter or that legal proceedings are on foot.

142 In addition, there is the independent role performed by IMHA, which provides advocacy to people who are receiving compulsory mental health treatment with a focus on rights under the Mental Health Act and supported decision-making. The MHCC meets regularly with IMHA as part of a protocol which supports the sharing of themes identified in our respective roles, and referrals between the two offices.

Existing gaps, overlaps or duplication of roles, responsibilities, functions or processes of the Mental Health Complaints Commissioner and other oversight bodies

Overlaps and intersecting responsibilities

143 Although MHCC has some overlapping and intersecting responsibilities with other oversight bodies, all of these agencies have a different focus and role. To the extent that there is a potential overlap, the MHCC has developed practice arrangements and protocols with the Chief Psychiatrist, the HCC, AHPRA and the Public Advocate. These arrangements facilitate consultations and referrals, inform decisions about which is the most appropriate body to deal with a matter, and help us avoid any duplication. In deciding whether to accept or close a complaint, the MHCC considers whether the complaint (or part of the complaint) is being considered or investigated by another body, or has been considered or determined by another body.[71]

144 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. The MHCC meets regularly with the Chief Psychiatrist to discuss quality, safety and risk issues which have been identified from complaints and to decide on the appropriate courses of action. The Chief Psychiatrist also invites the MHCC to contribute to working groups and projects, as well as regular quality and safety forums. The Chief Psychiatrist was represented on the MHCC's sexual safety project reference group, which resulted in *The Right to Be Safe* report, which has in turn resulted in a program of work being implemented and progressed by the Chief Mental Health Nurse and the Office of the Chief Psychiatrist's Sexual Safety Committee.

[71] See *Mental Health Act* ss 240(1)(a)–(d).

Gaps

145 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 (unless we are conducting an investigation). Such powers are available to oversight bodies in other jurisdictions such as the DSC.[72] The MHCC does not have the equivalent powers to those of either the DSC or the HCC to investigate safety and quality issues in services without a valid complaint made under the Act.

146 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. For example, the MHCC does not have an "authorised officer" power or discretion to visit a service to obtain evidence prior to notification of an investigation, compared to those powers of the DSC which can be exercised where there are concerns that the "health, safety or welfare of a person may be affected" or the "proper investigation of the complaint would be prejudiced".[73] In some circumstances, this may limit the MHCC's capacity to respond in a timely way to seek further information or obtain evidence in response to potential significant safeguarding issues that may be raised in an enquiry or complaint.

147 In mental health, there is not the equivalent oversight to individual incidents relating to alleged assaults and abuse or unexplained injuries (that are not classified as sentinel events) compared to the role of the DSC or the operation of the Client Incident Management System (**CIMS**) which applies for in scope department funded community organisations.[74] The CIMS provides oversight to services' responses and investigation of such incidents in community services. Since 2012, the DSC has been empowered to independently review all category one incidents of alleged assaults and abuse or unexplained injuries in disability services. In contrast to the DSC, the MHCC does not 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 Chief Psychiatrist receives reports on some types of incidents, such as the use of restrictive interventions and sexual safety breaches, but this role is not equivalent to the breadth of oversight of CIMS nor the independent review role performed by the DSC in relation to the adequacy of services' responses and investigation of all category one incidents. The MHCC has been exploring ways of sharing data with the Chief Psychiatrist, Safer Care Victoria and VAHI related to these types of incidents in

[72] See *Disability Act 2006* (Vic). See also Disability Services Commissioner, 'What We Do', (2020) <https://www.odsc.vic.gov.au/about-us/what-we-do/#oversight>.
[73] See *Disability Act 2006* (Vic) ss 120,127–8, 132B–K.
[74] See DHHS, 'Client Incident Management System', (19 February 2020) <https://providers.dhhs.vic.gov.au/cims>.

order to increase the oversight and coordinated responses to these avoidable harms in services.

148 There are also restrictions on the circumstances under which the MHCC can accept an anonymous or whistleblower-type complaint about issues of safety or potential abuse or neglect. If the MHCC accepts a complaint, a written notification must be provided to the consumer "as soon as practicable".[75] That is the case even where there are serious safeguarding issues raised in the complaint and there are risks associated with notifying the consumer—risks either to the consumer's wellbeing or to the wellbeing of others.

149 A further gap in the legislative and oversight framework arises where health services that are not Designated Mental Health Services provide treatment and care to compulsory patients. The jurisdiction of the MHCC (and the Chief Psychiatrist) relates to "mental health service providers", which is defined to include Designated Mental Health Services, and does not include other health services under the *Health Services Act 1988* (Vic). I discuss the implications of this gap below.[76]

150 In addition to the specific gaps identified in relation to existing oversight mechanisms, there is also the gap that the MHCC's role does not include the broader independent oversight, monitoring and strategic functions that are performed by mental health commissioners or equivalent bodies in other jurisdictions. For example, in New South Wales, the Mental Health Commission's role includes "to monitor and report on the implementation of strategic plans prepared by the Commission and approved by the Minister" and "to review and evaluate, and report and advise on, the mental health and well-being of the people of New South Wales including conducting systemic reviews of services and programs provided to people who have a mental illness and other issues affecting people who have a mental illness". While the MHCC's role has the benefit of service and system improvements being driven by the issues raised by consumers, families and carers about their experiences, Victoria does not have the equivalent independent oversight and broader system monitoring and advisory function that is performed by mental health commissioners or equivalent bodies in other jurisdictions. This was evident, for instance, in the formulation of the National Mental Health and Wellbeing Pandemic Plan and the corresponding state and territory plans.[77]

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[75] See *Mental Health Act* s 243(1).
[76] See below at paragraph [194].
[77] See above at paragraph [104].

Strengthening and improving regulation and independent oversight

Ways of improving the transparency of regulatory and oversight mechanisms

151 Several reviews, including the *Targeting Zero* report in Victoria, and the recently released report on the review of clinical governance of public mental health services in Western Australia,[78] have highlighted the importance of achieving and monitoring a 'whole of system' picture of safety, quality and incident data, which includes indicators of consumer experiences through complaints and feedback data. The option of a 'safety report card' for public mental health services has been advocated by consumers, both in Victoria and interstate, as a way of improving the transparency and effectiveness of regulatory and oversight mechanisms, and for driving service improvements.[79] The MHCC has been working on ways in which complaints data can be shared and combined with other indicators of quality and safety to achieve these goals.

Sharing complaints data

152 Sharing service-level complaints data is an important way to increase transparency about the nature of people's experiences within the mental health system, and support consumers, carers and services to identify opportunities for service improvement. The MHCC is working towards making service-level complaints data publicly available in a way that it can reliably and meaningfully be interpreted alongside other indicators of quality and safety in services. This service-level complaints data has not yet been published for two key reasons. Firstly, there continues to be considerable variability in the recording and reporting of complaints by services. As a first step to making more data publicly available and encouraging stronger recording and reporting of complaints, the MHCC is progressing plans to share service-level data comparing complaint rates per 1000 consumers for individual services, for both complaints made to the MHCC and complaints made directly to services. This data provides a sense of how well the service identifies, records and addresses complaints at the local level. There is significant variability in patterns across services, with some services recording high numbers of local complaints and low numbers to the MHCC, which indicates services are largely responding well to people's concerns. Other services report low local complaint numbers but high numbers to the MHCC, which indicates that complaints systems and cultures at that service could be improved. Complaints are only one part of services' feedback systems, which also record compliments and suggestions for improvements. While the MHCC's power under s 267 of the Act does not include requesting data about

[78] Government of Western Australia, 'Review of the Clinical Governance of Public Mental Health Services in Western Australia, Final Report October 2019' (Released March 2020) <https://ww2.health.wa.gov.au/Reports-and-publications/Review-of-the-clinical-governance-of-Public-Mental-Health-Services>.

[79] Ibid, p 32; see also VMIAC, 'Seclusion Report: How safe is my hospital?' April 2019 <https://www.vmiac.org.au/seclusion-report-how-safe-is-my-hospital/>.

compliments and suggestions, we intend to explore with services whether they would be willing to share the number of compliments and suggestions they receive, to provide a fuller picture of how their complaints and feedback systems are working.

153 The second and more significant reason that the MHCC has not yet published service-level complaints data is that complaints data alone is not a reliable indicator of service quality. Complaints represent only a portion of people's experiences and numbers of complaints alone do not represent service quality. Sharing this data without further context has the risk of incorrect conclusions being drawn about the nature of people's experiences and the quality of individual services.

154 The MHCC has, however, encouraged services to use and share their own complaints data within their own services with consumers, families and carers and advisory groups, so that people can see the issues raised in complaints and how the themes from complaints have been used to inform service improvements. The MHCC has sought input from consumers, carers and services on format and content of individual service provider complaint reports that the MHCC provides to each service, in order for these reports to communicate the types of information and analysis that each of these stakeholders will find most useful. The MHCC is continuing to work on improving the accessibility and efficacy of these reports as part of the efforts to strengthen and improve the oversight of quality and safety issues in services.

155 The MHCC is also progressing plans to share more detailed service-level complaints data publicly and enable comparisons with other data sources, such as incident reporting data and results from the Your Experience of Service (**YES**) survey and the Carer Experience of Service (**CES**) survey. This would provide a more complete picture of people's experiences, and enable the data to be used by consumers, families, carers and services to identify key areas for attention and to drive service improvements. The MHCC has had several preliminary discussions with VAHI to discuss ways of combining different sources of consumer experiences, including YES survey results and themes from complaints to the MHCC and to services.

156 We are also in the process of exploring ways in which we may be able to contribute complaints data or learnings from complaints to VAHI's reports, such as VAHI's *Inspire* reports, and to the work of SCV. Recent amendments to the *Mental Health Regulations 2014* (Vic) have introduced SCV and VAHI as prescribed bodies to which the MHCC may provide information under s 228(j) of the Act. Since the passage of these amendments, we have provided copies of all of the individual service provider complaints reports for the periods 2015–16, 2016–17 and 2017–18 to SCV and VAHI, which include a sector wide comparative analysis across these three years. We have also provided these reports to the Secretary of the DHHS. We will continue to seek opportunities to discuss how

complaints data and learnings from complaints can contribute to the DHHS's work in monitoring and improving service performance.

157 The MHCC has published the statewide complaints data for the periods 2015–16, 2016–17 and 2017–18 on its website. The MHCC will also make publicly available the statewide data from the 2018–19 and 2019–20 reports, as soon as these reports are completed.

Reporting by DHHS

158 The MHCC has advocated for more transparent reporting of serious incidents that occur within mental health services. In *The Right to Be Safe* report, we recommended that the DHHS consider mechanisms for ensuring services are accountable for preventing breaches of sexual safety in acute mental health inpatient units (such as by including the prevention of sexual safety breaches in Statements of Priorities). The MHCC also recommended that a comprehensive sexual safety strategy be developed, and that this strategy should include performance measures for services and the inclusion of sexual safety in quality and safety reports across mental health services.

159 We note that the DHHS accepted all the recommendations that the MHCC made in *The Right to Be Safe* report. However, the DHHS has not yet advised us of specific actions to create performance measures for services relating to sexual safety, or to include sexual safety in quality and safety reports.

A stronger role for people with lived experience in oversight mechanisms

160 Since the MHCC's establishment, we have welcomed and encouraged applications from people with lived experience for all roles within our office. Our Senior Advisor, Lived Experience and Education, has a strategic role within our office, providing advice to inform our approaches across all areas of our work. As noted earlier, our current Deputy Commissioner, Maggie Toko, also brings lived experience expertise to her key leadership role in the MHCC. Both positions sit on the MHCC's Leadership Group to ensure that our decisions are directly informed by lived experience advice and expertise.

161 The MHCC's Advisory Council began operating in 2016 after an extensive consultation process. The establishment of the Advisory Council was led by Dr Anthony Stratford, a lived experience leader, who is also Chair of the Council. The Advisory Council is a key way we ensure our work is informed and driven by people with lived experience. The concept of lived experience includes the experiences of consumers, families, support people and carers, and people who work in mental health services. Members of the Advisory Council draw on their personal and professional expertise and experiences to give us strategic advice and insights, to collaborate on our projects, and to inform changes to our practice.

162 There are always more opportunities to improve how people with lived experience can play a role in every part of the mental health service system including in oversight mechanisms. The MHCC continuously seeks opportunities to improve how every aspect of our work can be informed and driven by lived experience. We have a dedicated "Driven by Lived Experience" project team led by our Senior Advisor, Lived Experience and Education, that is working closely with our Advisory Council to finalise a lived experience framework and principles for engagement. This team comprises staff from across our office and works to ensure that the MHCC engages early and meaningfully with lived experience expertise in the development of projects and policies (either through engagement with staff with lived experience, Advisory Council members, or broader engagement, as appropriate to the nature of the work). As part of this work, the team is seeking input from Advisory Council members to identify and prioritise those areas where expanding and strengthening how our work is driven by lived experience will have most impact both for improving the experiences of the people who contact us, and for influencing service and system improvement.

163 Complaints are also a direct reflection of people's lived experience. In every aspect of our work, the MHCC is informed and guided by the experiences that people report to us.

Service safety

Fundamental factors that contribute to safety risks within Victorian mental health services

164 The MHCC considers safety from a broad perspective, as encompassing physical, sexual, emotional, cultural and psychological safety. People must feel safe as well as be safe while accessing mental health services. Feeling psychologically, culturally or emotionally unsafe within mental health services can both cause harm, and can contribute to reluctance to seek help from the service in the future.

165 Many factors contribute to people not being or feeling safe in mental health services. I will discuss six of these: resourcing challenges; outdated infrastructure; lack of choice, autonomy and control; cultural challenges; staffing challenges; and lack of widespread access to sensory tools.

166 First, resourcing challenges mean many people do not receive the right care at the right time. Resourcing challenges cause issues such as:

(a) premature discharge from acute inpatient care;

(b) excessive wait-times in ED for an acute inpatient bed (which can lead to the use of restraint or sedation while in the ED, where these interventions may have been

able to be avoided if a person had been able to access a more appropriate form of care);

(c) inability to access treatment and care in the community (which can lead to a worsening of mental health); and

(d) inability of staff to engage with consumers in a meaningful and therapeutic way.

167 Secondly, outdated infrastructure can lead to people feeling unsafe in mental health services. Infrastructure issues include:

(a) poor visibility of many areas of the unit (including corridors, bedrooms, outdoor areas, bathrooms and women's corridors) meaning staff are unable to observe many areas of the unit;

(b) inconsistent availability across services of infrastructure that supports sexual safety including lockable doors, separate bedrooms and ensuites;[80]

(c) lack of ability within Intensive Care Areas to separate people with different care needs (this may include people who have been identified as highly vulnerable as well as people who have been assessed as being a high risk of causing harm to others); and

(d) lack of consistent access across services to pleasant areas within inpatient units that support people's wellbeing, including access to outdoor areas (including outdoor areas for Intensive Care Areas and women-only outdoor areas), sensory rooms and natural light.

168 Thirdly, people can feel unsafe because of a lack of choice, autonomy and control. For people who are likely already to have a trauma background, the high use of coercive practices can re-traumatise people. Potentially re-traumatising practices include compulsory assessment and treatment, being subject to restrictive interventions, observing the use of restrictive interventions on others, and coercive transfers to hospital (for example, by police or with police involvement). Not only may the excessive use of coercive practices fail to help a person at the time of their admission, it may also result in a future reluctance to seek help from mental health services.

169 Fourthly, there are cultural challenges that may contribute to people feeling unsafe in mental health services. As the MHCC observed in our Submission, we are yet to observe the transformation in service culture that the Act envisaged, to create cultures where human rights are foundational to the treatment and care provided within services. The

[80] I note that the Department has completed an audit of this infrastructure as recommended in *The Right to Be Safe* report. Mental Health Complaints Commissioner, *The Right to Be Safe* (2018), p 62.

creation of "positive complaints cultures", where people feel confident and supported to speak up about any concerns, is also foundational to safety within services.

170 Fifthly, staffing challenges may contribute to people feeling unsafe in mental health services. It is not uncommon for services to use agency staff to ensure they can fill staff rosters. Agency or bank staff are unlikely to be familiar with service policies and procedures. They are unlikely to have received the same access to training as permanent staff, and may be unaware of all options within the service that would enable them to respond to a consumer's individual needs.

171 Finally, a lack of widespread access to sensory tools may contribute to people feeling unsafe. While some inpatient units have access to sensory rooms and tools, to our knowledge these are rarely available in ED and are not uniformly available in all units. Nor are all staff trained in their use. Tools and spaces for sensory modulation can help a person to manage their symptoms. Lack of access to these tools and spaces, whether because they are not available, staff are not trained in their use, or because allocating a staff member to support the use of the sensory room places pressure on staffing numbers elsewhere in the unit, may be one contributing factor to the unnecessary use of coercive practices.

Key changes required to improve staff and consumer wellbeing

172 Consumer and staff safety are intertwined. While the MHCC does not have jurisdiction to take complaints about staff experiences, our learnings from complaints from consumers, their families, and carers suggest that actions that are taken to ensure the safety of consumers would also promote staff safety. I will briefly discuss four changes that could improve safety for all: reduction in the use and duration of coercive practices; better staff training, professional development and supervision; systems and structures that enable different ways of working; and a stronger peer workforce.

173 First, it is a priority to reduce the use and duration of coercive practices. This includes reducing the rate of coercive treatment including compulsory treatment and the use of restrictive interventions. Reducing the rate of compulsory treatment may be difficult without additional resources; however, reducing the use of coercion also requires building a culture where human rights are understood, valued and applied in providing care. Alternatives must be explored or considered and found to be unsuitable before any restrictive interventions are used, and any use of such practices kept to the absolute minimum that is necessary to ensure the safety of the individual or another person.

174 Secondly, it is critical to improve staff training, professional development and supervision. Complaints have included some instances where staff were ill-equipped to support a consumer experiencing an acute mental health episode, which should be a fundamental

skill for staff working in public mental health services. A lack of skill to manage a person's behavioural symptoms can lead to the person's treatment being more restrictive than could be achieved if staff had a greater degree of skill. However, the most common issue the MHCC observes in complaints is a poor understanding of staff and service responsibilities under the Act. This is particularly common in complaints relating to experiences in EDs. Another common issue is a poor understanding of the gravity of the decision to use compulsory treatment, and of the limitations that compulsory mental health treatment places on a person's human rights.

175 Thirdly, systems and structures need to be changed to enable different ways of working. This includes ensuring that priority is given to spending time with consumers[81] and that decisions are made *with* the consumer (and their family or support people), not *for* them. Examples of opportunities to change structures include shift handover, complex care committees and other collaborative care meetings.

176 Finally, strengthening the peer workforce would improve safety for all. This includes giving the peer workforce greater involvement in systems and structures like clinical meetings and handovers, to support consumers' voices in decision-making and ensure these processes and meetings are conducted in ways that enable the peer workforce to meaningfully contribute. Strengthening the peer workforce requires dedicated support to expand, support and develop this workforce including through the kinds of initiatives established through the recommendations in the Royal Commission's Interim Report.

Occupational safety

Complaints about occupational safety from or on behalf of people working in the mental health system

177 Under s 234 of the Act, the MHCC has jurisdiction to take complaints about any matter arising out of the provision of mental health services or any failure to provide mental health services by a mental health service provider. Section 232 of the Act provides that complaints may be made by a consumer, by another person at the request of a consumer, or by any person with a genuine interest in the wellbeing of a consumer. There is no provision for dealing with complaints from staff about staff experiences including occupational safety.

178 My office does receive a small number of complaints from mental health staff raising issues about the work culture and practices within mental health services. Occupational safety may sometimes be included in the issues raised and have been general in nature. As these complaints are outside the MHCC's jurisdiction, the MHCC provides advice and

[81] Over 190 people contributed to consultations that informed VMIAC's *Declaration of something wonderful* (2019). Conversations and listening were strong themes of these consultations and many people raised the need to be heard by another person.

referrals as appropriate to the particular issues raised. However, as observed in the discussion above about service safety, the safety of consumers and staff are intertwined, and the factors discussed above in paragraphs 164 to 171 may also assist in supporting occupational safety.

Compulsory treatment

Common issues raised in complaints about the use of compulsory treatment

179 The MHCC receives complaints about the use of compulsory treatment. Some of the issues that are commonly reported in these complaints are outlined below.

Disagreement with Assessment or Treatment Orders

180 Disagreement with a Treatment Order was raised in 778 complaints (11% of all complaints), and disagreement with an Assessment Order was raised in 130 complaints (2% of all complaints). The total proportion of complaints about orders has risen from 8% to 18% since 2014–15. An often co-occurring issue is concern that staff have not sought or responded to the views and preferences of the consumer, or their family member/carer or nominated person about the degree of intervention that was necessary to ensure the person could be assessed or access treatment. In many complaints, the MHCC has assessed that the person's assessment or treatment could have been less restrictive. For example, the person could have:

(a) been assessed or treated by the Designated Mental Health Service on a voluntary basis;

(b) accessed treatment from a private mental health provider; or

(c) been assessed or treated in the community rather than in an ED or an inpatient unit.

181 The MHCC observes that, in the complaints that are dealt with by our office, the restriction of human rights inherent in using compulsory assessment and treatment (particularly inpatient orders that authorise detention), is not routinely considered in decision-making.

Medication

182 Complaints about compulsory treatment also raise issues relating to medication. These include side effects from medication (399 complaints, 6% of all complaints), unnecessary medication (153 complaints, 2% of all complaints) and preference for oral over depot medication (113 complaints, 2% of all complaints). The total proportion of complaints about these medication issues has risen from 4% to 16% since 2014–15. As above, complaints about medication issues often include concerns about how staff have responded to the person's views and preferences about medication. While in some

instances, services are able to provide an outline of how the person has been supported to participate in decisions about medication, what options have been tried and considered, and how they have attempted to respond to the person's known views and preferences while maintaining effective treatment, this is not always the case.

Communication

183 Complaints about compulsory treatment also raise issues about communication. These include inadequate communication about compulsory status (306 complaints, 4% of all complaints), the statement of rights delayed or not provided or explained (159 complaints, 2% of all complaints),[82] and insufficient information about Mental Health Tribunal processes and appeal rights (56 complaints, 1% of all complaints). As I discuss below,[83] people do not always receive a copy of their Assessment or Temporary Treatment Order and statement of rights. In addition to this, we observe that, nearly six years on from the commencement of the Act, cultural change is still required to view discussions about rights as ongoing discussions during the course of a person's engagement with a service, and not as a "tick-box" exercise during admission.

Rights

184 Some complaints have related to a person's statement of rights or to a lack of support in contacting the Mental Health Tribunal. Issues that have arisen in these complaints include:

(a) compulsory patients not being provided with their statement of rights, or it was only provided on request;

(b) staff not verbally explaining a statement of rights, including to consumers who had literacy issues;

(c) 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;

(d) a statement of rights only being provided after a delay;

(e) a statement of rights not being provided or explained to the carers of a child; and

(f) treating teams not informing compulsory patients about their right to appeal to the Mental Health Tribunal, explaining the appeal process or providing the forms required to make an application for revocation of a Treatment Order.

[82] A statement of rights is a document that sets out a person's rights under the Act while that person is being assessed or receiving treatment in relation to their mental illness. See *Mental Health Act* ss 12–13.
[83] See below at paragraphs [190]–[192].

185 The MHCC has also received a complaint where a person for whom English was not their first language did not have access to an interpreter in order to understand and exercise their rights. In another complaint, a person was assessed as "agitated" and placed on an Assessment Order after speaking to staff in a language other than English. In this instance, staff did not seek to consult with an English-speaking family member who was present to understand what was said, before placing the person on the order.

186 Small numbers of complaints have also been made about the statutory process for making or reviewing an Assessment or Temporary Treatment Order not being followed and records or reports not being provided 48 hours prior to a Mental Health Tribunal hearing.

Necessary changes to the use and oversight of compulsory treatments

187 Overall, I note the lack of consistent understanding within mental health services about the gravity of the decision to initiate compulsory assessment or treatment. I also note the lack of oversight or monitoring of the rate and duration of use of Assessment Orders and Temporary Treatment Orders (where an order is revoked before a hearing occurs before the Mental Health Tribunal).

188 In the MHCC's Submission, we noted that 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"[84]. One of the criteria for making compulsory Treatment Orders is that "there is no less restrictive means reasonably available to enable the person" to be assessed[85] or to receive immediate treatment.[86] 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. The 'no less restrictive means' criteria is 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.

189 As the MHCC noted in its Submission:

> 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,

[84] *Mental Health Act* s 11(1)(a).
[85] *Mental Health Act* s 29(d).
[86] *Mental Health Act* s 5(d).

including the requirement to provide assessment and treatment in the least restrictive way possible.[87]

190 Complaints to the MHCC indicate that the legislative requirement to give the person a copy of the order and a copy of the relevant statement of rights, "to the extent that is reasonable in the circumstances",[88] is not always met. I have outlined above the themes that arise from complaints about statements of rights.[89]

191 The MHCC has observed a widespread practice that a person who is placed on an Assessment Order is not reviewed by an authorised psychiatrist (or delegate) until the next day although the legislative requirement is for an examination "as soon as practicable".[90] In many complaints to our office, when the person was assessed the person's order was revoked by the authorised psychiatrist on the basis that the criteria were not met. This may indicate a need for greater education and support for mental health practitioners about the use and purposes of Assessment Orders, and an auditing or oversight mechanism for the use of orders would assist in identifying services most in need of support.

192 Further, the MHCC has received complaints where a service has failed to prioritise the assessment by the authorised psychiatrist, even though the person is mechanically restrained.

193 In light of the frequency with which these issues have been raised, in 2018-19, the MHCC made a recommendation to the Secretary of the DHHS and the Chief Psychiatrist to 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 Act. This recommendation included considering the training content and requirements and considering a state-wide approach to the development of training resources and a training program.

<u>Oversight of decision-making in services that are not Designated Mental Health Services</u>

194 As outlined above,[91] there are particular issues in the provision of compulsory treatment in EDs of health services that are not Designated Mental Health Services. The jurisdiction of the MHCC (and the Chief Psychiatrist) relates to "mental health service providers", which is defined to include Designated Mental Health Services, and does not include other health services under the *Health Services Act 1988* (Vic).

[87] Submission (July 2019) section 4.6.
[88] *Mental Health Act* s 32(1)(b).
[89] See above at paragraphs [179]–[186].
[90] *Mental Health Act* s 36(1).
[91] See above at paragraph [149].

195 Arrangements 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 for the purposes of the Act, and accordingly the MHCC does not have jurisdiction in relation to Northern Health and Western Health.

196 One issue is where key decisions about a person's treatment and care and the use of restraint are made by clinicians who are not employed or engaged by a Designated Mental Health Service. The MHCC does not have jurisdiction to investigate health services that are not Designated Mental Health Services. I am therefore limited in the findings that I can make about the decisions and actions of the health service's clinicians and security staff and the person's experience. Part 6 of the Act governs the use of restrictive interventions on a person "receiving mental health services **in**" a Designated Mental Health Service.[92] The Chief Psychiatrist has issued a guideline, which outlines the interpretation of Part 6 to be applied where a person is taken to an ED that is not part of a Designated Mental Health Service where the person is subject to an Assessment Order.[93] I do not believe this is a satisfactory legal position given the gravity of the decision to use restrictive interventions. In any event, it does not give my office jurisdiction in relation to the decisions and actions of staff employed or engaged by a health service that is not a Designated Mental Health Service, or to investigate the consumer's experience in so far as it does not relate to the Designated Mental Health Service.

Scope for the collection and publication of compulsory treatment data to reduce the use of compulsory treatment

197 The MHCC is not in a position to comment on whether publication of data is likely to reduce the use of compulsory treatment.

198 The Mental Health Tribunal currently publishes quarterly statewide information about the number and duration of Treatment Orders made by the Mental Health Tribunal and number of orders made permitting ECT. Service-level data is not currently publicly reported, nor are we aware of any reporting (public or otherwise) of the rate of use or duration of Assessment Orders or Temporary Treatment Orders.

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[92] *Mental Health Act* s 105 (emphasis added).
[93] Department of Health, Victoria, 'Restrictive Interventions in Designated Mental Health Services', (July 2014) <www2.health.vic.gov.au/about/publications/policiesandguidelines/Restrictive-interventions-in-designated-mental-health-services>.

199 In addition, rates of compulsory treatment are published annually by the DHHS in an annual report.[94]

200 The MHCC supports the sharing of data between services for benchmarking purposes, as well as the introduction of mechanisms to stimulate discussions and support services to learn from each other about ways to reduce the use of compulsory treatment.

201 We note that there is currently no oversight of the use of Assessment Orders. Further, there is no oversight of the use and duration of Temporary Treatment Orders if the order is revoked before the Mental Health Tribunal hearing. A mechanism to audit and benchmark the use and duration of Assessment Orders and Temporary Treatment Orders would be valuable.

202 Any mechanism or plan for public reporting of data about compulsory treatment should be developed together with consumers, carers and mental health services. Different services work with different populations, have varying levels of resource available to them and different challenges. Any public reporting should be sensitive to the individual circumstances of mental health services, particularly given services are currently catchment-based, and consumers have no choice about which area mental health service they can access. There is a clear public interest in reporting data as transparently as possible, provided that this can be done in a way that recognises the circumstances and efforts of individual mental health services, and avoids creating unnecessary or unwarranted concern from consumers, their families and carers.

Improving the take up of safeguards by consumers, families and carers

Statutory mechanisms for nominated persons, advance statements and second psychiatric opinions

203 The Act contains several statutory mechanisms that are intended to support the implementation of a supported decision-making model within mental health services, including nominated persons, advance statements and second psychiatric opinions. We often suggest these outcomes as part of the complaint resolution process.

204 The rate of use of nominated persons and advance statements remains extremely low and has remained at between 2% and 3% for adults aged 18 to 64 for the last three financial years.[95] Given the low rate of advance statements recorded, it is not surprising that relatively few complaints have been made about the use of advance statements. From July 2014 to June 2019, 73 complaints (1% of all complaints received) concerned

[94] See, eg, DHHS, 'Victoria's Mental Health Services Annual Report 2017–18' (2018) <https://www.dhhs.vic.gov.au/publications/victorias-mental-health-services-annual-report-2017-18>.
[95] DHHS, *Mental Health Services Annual Report 2018–19* (2019) 87.

advance statements. Issues raised with the MHCC in relation to advance statements include:

(a) staff either involving or not involving consumers' families against their wishes set out in their advance statement;

(b) consumers' concerns that they will be given ECT, depot injections or other medications despite their wishes as set out in their advance statement;

(c) consumers' wishes about the location of treatment (either about a particular service or location in the service including ICA) as set out in their advance statement not being considered;

(d) lack of consideration of previous experiences of trauma as set out in an advance statement, in making treatment decisions (for example not considering the trauma associated with the use of restrictive interventions, searches, or witnessing traumatic events);

(e) people's wishes with regard to communication strategies not being considered or adopted; advance statements not being located or considered at all as part of making a treatment decision; and

(f) services not assisting consumers to make advance statements.

205 The MHCC has received very few (20) complaints that relate to nominated persons. Issues raised in complaints about nominated persons commonly include nominated persons not being notified about key events including the consumer being placed on an order or the use of a restrictive intervention, as well as concerns that the nominated person's views have not been considered by staff.

206 A total of 119 complaints were received about access to second opinions between 1 July 2014 and 30 June 2019 (2% of all complaints). Issues raised in these complaints included:

(a) consumers not being able to access a second opinion;

(b) consumers asking to see a different psychiatrist and being refused;

(c) compulsory patients not being provided with information about the right to a second opinion;

(d) delay in obtaining second opinions, sometimes due to delays in transferring medical reports; and

(e) concerns about the independence of second opinions provided from within the treating service.[96]

[96] This is a longstanding concern of consumers and one of the reasons for the establishment of the second psychiatric opinion service.

207 Feedback from consumers, families and carers through complaints indicates that there is both a lack of awareness and confidence in these safeguards and mechanisms for supported decision-making, and therefore there is a need for proactive approaches by services and broader education strategies to increase uptake.[97]

208 Given the link between previous experiences of trauma in people accessing public mental health services, which are often characterised by a lack of control and disempowerment, supporting people to exercise autonomy and make choices is also a critical trauma-informed care strategy that could greatly improve people's experiences of accessing mental health treatment.

Safeguards through complaint mechanisms

The right to make a complaint

209 The right to make a complaint, and feeling comfortable and safe to speak up about concerns about their experiences of treatment, is foundational to people being able to exercise their other rights. The number of complaints raised with the MHCC over the five years to 30 June 2019 demonstrates the success of the MHCC's flexible approaches to support people to make a complaint and participate in the complaints process.

210 The MHCC receives between seven and 10 times the number of complaints made in other Australian jurisdictions, and between four and five times what was predicted prior to the MHCC's establishment.[98]

211 However, on average, about 36% of consumers in public mental health services each year have not accessed public mental health services in the previous five years.[99] This means that a significant proportion of consumers are likely to be unaware of the safeguards available to them (including complaint mechanisms). Ongoing engagement work (both with mental health services and with the broader community) therefore remains necessary to ensure that people who access public mental health services are informed of complaint mechanisms and feel supported and safe to make complaints about their treatment and experiences within mental health services. To raise awareness of the right to make a complaint among communities who are likely to face particular barriers to speaking up about their experiences, the MHCC has a particular focus on attending and participating in events, working with our partners and maximising our social media presence to engage with Aboriginal Victorians, LGBTIQ+ Victorians, older people and younger people.

[97] See further examples of complaints relating to supported decision-making in Attachment LCB-5.
[98] For more detail, see above at paragraphs [69]–[75].
[99] DHHS, *Mental Health Services Annual Report 2018–19* (2019) 84.

Local complaint mechanisms

212 The MHCC's comparative analysis of complaints made to services and complaints made to the MHCC, along with feedback from consumers, families and carers, indicates that in many services, people may not be sufficiently aware of their right to make a complaint or sufficiently confident to make a complaint directly to the service. Further, the local complaints reports (which have been provided to the Royal Commission) indicate wide variability in the rate of complaints reported by mental health services, compared to complaints made to the MHCC in relation to that service.

213 A high rate of complaints to the MHCC combined with a low rate of complaints reported by the service indicates a need for services to improve how well they identify, support people to make, and record local complaints. The MHCC's assessment is that most services need to improve how they identify, record and respond to complaints made directly to their service. For example, we have received complaints where the service has advised that the original complaint made by the person has been lost, or where the person reports there was no response to the complaint made locally.

214 We note that some services have responded positively and proactively to receiving comparative data and to complaints from our office, using these as opportunities to identify improvements that can be made at their service. We welcome these responses and seek to continue to work with services to support their efforts to improve services.

Complaints by carers

215 The Act does not give carers a right to make a complaint to the MHCC in their own right about their experience and treatment (although the role of carers is recognised in the principles and carers have rights under the Act). This limits the access to complaint resolution processes for carers. In comparison, other legislative schemes provide for carers to make complaints about their treatment and experience as a carer.[100] The introduction of a similar provision to the Act would improve and increase the complaint resolution options available to families and carers.

Restrictive practices

Proportion of complaints received by the Mental Health Complaints Commissioner that relate to the use of restrictive practices, including physical, mechanical or chemical restraints or seclusion

216 In the period from 1 July 2014 to 30 June 2019, the MHCC received 266 complaints about the use of restrictive interventions, including mechanical restraint, physical restraint and

[100] See, eg, *Health Complaints Act 2016* (Vic) s 7; *Health and Disability Services (Complaints) Act 1995* (WA) s 19.

seclusion. Complaints about restrictive interventions have been stable at 4% of all complaints each year from 1 July 2014 to 30 June 2019. People may face particular barriers to making complaints about their experiences of seclusion and restraint, including not wanting to revisit what has been a very traumatic experience, and therefore these complaints are likely to be under-reported.

217 The use of chemical restraint is not regulated by the Act so there is no issue category that specifically reflects this. However, over-sedation was raised in 61 complaints (1% of all complaints), and 153 complaints raised issues of unnecessary medication (2% of all complaints). Both of these issue categories include concerns reported by consumers that their medication was excessive and that, in their view, it was prescribed for behavioural rather than treatment reasons. The question of when sedation constitutes chemical restraint, and whether and how it should be regulated, has been the subject of consideration in many forums.[101]

218 The most common issues raised in complaints about restrictive interventions were:

(a) excessive force or alleged assault by clinical or security staff in the use of physical restraint (90 complaints, 1% of all complaints);

(b) seclusion was considered unnecessary (65 complaints, 1% of all complaints);

(c) physical restraint was considered unnecessary (42 complaints, 1% of all complaints);

(d) mechanical restraint was considered unnecessary (36 complaints, 1% of all complaints);

(e) inappropriate seclusion environment or amenities (31 complaints, less than 1% of all complaints);

(f) excessive force or alleged assault by security staff in the use of physical restraint (31 complaints, less than 1% of all complaints);

(g) lack of dignity or rights in the use of mechanical restraint (15 complaints, less than 1% of all complaints);

(h) lack of dignity or rights in the use of physical restraint (15 complaints, less than 1% of all complaints); and

[101] See, eg, Northern Territory Health and Community Services Complaints Commission, 'Investigation: Legal Rights and Issues and ECT in Relation to a Mental Health Inpatient Admission', (8 August 2019) <https://www.hcscc.nt.gov.au/resources/case-studies/>. This report refers to a legal opinion from Professor Bernadette McSherry about the different regulatory approaches in Australia to chemical restraint, and recommends that chemical restraint should be regulated in the mental health context in the Northern Territory. See also VMIAC, 'Seclusion Report: How Safe Is My Hospital?' (April 2019) <https://www.vmiac.org.au/seclusion-report-how-safe-is-my-hospital/>. In this report VMIAC calls for data to be reported on the use of "chemical and psychological restraint".

(i) lack of dignity or rights in the use of seclusion (13 complaints, less than 1% of all complaints).

219 The MHCC also receives complaints about other aspects of the use of restrictive interventions, in particular where there are departures from the provisions set out in the Act, or approved guidelines. These have included:

(a) inadequate authorisation for mechanical or physical restraint or seclusion (a total of four complaints);

(b) inadequate documentation of mechanical or physical restraint or seclusion (a total of three complaints);

(c) inadequate clinical monitoring for mechanical or physical restraint (a total of five complaints);

(d) inadequate medical review or observation of consumers in seclusion (a total of four complaints);

(e) approved guidelines not adhered to for mechanical or physical restraint or seclusion (a total of six complaints); and

(f) nominated person or carers not notified (a total of one complaint).

220 A detailed review of complaints revealed that a number of consumers who presented in crisis to EDs raised concerns that they were subjected to bodily restraints that were either unnecessary, used for an unjustifiably long period, or for which no adequate explanation was given.[102] This was particularly true of mechanical restraint. This situation often occurred following lengthy waits, or attempts by consumers to leave the ED. Consumers also reported that the use of mechanical restraint in EDs left them feeling deprived of their dignity.

221 Consumers also experienced what they considered unnecessary and excessive physical restraint on inpatient units. These experiences usually involved the forcible administration of medication by injection, with the involvement of multiple members of staff. Many of these complaints are particularly traumatising for female consumers and consumers with a history of sexual assault (particularly when the consumer is restrained by multiple male staff). In the MHCC's assessment, in many of these cases the service could have avoided the use of physical restraint if the service had engaged better with the consumer and their support people. A service can engage better if it:

[102] "Bodily restraint" is defined in s 3 of the Act as meaning "a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs; but does not include the use of furniture (including beds with cot sides and chairs with tables fitted to their arms) that restricts the person's ability to get off the furniture".

(a) explains to the person why they need medication, including sensitively explaining the possible consequences of refusing medication;

(b) explores medication options with the person; and

(c) explores with the consumer's family and carer other strategies for avoiding the use of restraint.

222 The majority of complaints regarding the use of excessive physical force or alleged assault in relation to physical or mechanical restraint have related to clinicians. However, an emerging theme from recent complaints data is the increasing involvement of security staff. This is true of both ED and inpatient settings.

223 Consumers also experienced being placed in seclusion unnecessarily, without being given a reason, or for reasons they thought were insufficient. In a number of complaints, consumers also reported that services used excessive force in placing them in seclusion, causing injury.[103] In some instances consumers reported lengthy periods of seclusion, with little or no evidence of consideration of alternatives to seclusion.

224 Other themes in complaints about restrictive interventions include:

(a) insufficient evidence that a service considered less restrictive options before deciding to use restrictive interventions;

(b) non-compliance with the provisions of the Act relating to the use of restrictive interventions, including in relation to authorisation, monitoring, review, notification and reporting to the Chief Psychiatrist;

(c) failure to offer debriefing to a consumer after the use of a restrictive intervention, as expected by the Chief Psychiatrist's guideline on restrictive intervention;

(d) no evidence that the service undertook a formal systemic review of a restrictive intervention in accordance with the Chief Psychiatrist's guideline on restrictive interventions; and

(e) lack of dignity experienced during restrictive interventions, for example having to urinate in a seclusion room due to a lack of bathroom facilities or being undressed by staff to use a bed pan while in four-point restraints.

Psychological and physical impacts of bodily restraint and seclusion

Consumers of mental health services

225 Complaints to the MHCC indicate that restrictive interventions are highly intrusive practices that have a traumatic and enduring impact on consumers. There is widely

[103] For more details, see below at paragraph [227].

recognised and undisputed evidence of the harm and trauma experienced by people who are subject to such interventions.[104]

226 The MHCC has received 46 complaints (1% of all complaints) about excessive force or alleged assault by clinical staff in the use of physical restraint (46 complaints, 1% of all complaints), and 31 complaints about excessive force or alleged assault by security staff in the use of physical restraint.

227 Consumers have reported pain and physical injury as a result of the physical or mechanical restraints or excessive force used to place them in seclusion. These injuries include bruising and pressure injuries and in some instances broken bones. A recurring theme about the impacts on consumers is that those administering the restraint fail to consider the consumer's existing physical conditions or individual needs. More specifically, these failures have included:

(a) a lack 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);

(b) failure to consider gender-sensitive practice in the use of restraint (for example, where a woman was restrained by four male security guards); and

(c) 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 in deciding whether it was necessary to use restraint).

228 Many consumers have highlighted the psychological impacts of restrictive interventions, both during and after treatment. Restrictive interventions heighten anxiety and distress as they occur. Consumers frequently report ongoing psychological trauma, including symptoms of post-traumatic stress disorder. The psychological distress arising from the use of restrictive interventions has also led consumers to fear or avoid further mental health treatment.

229 Two critical strategies for implementing trauma-informed care are reducing the use of restrictive interventions, and increasing consumers' sense of autonomy and choice in their treatment. That these are critical strategies is evident from the high rates of previous trauma experienced by people accessing public mental health services, and the re-traumatising nature of the use of restrictive interventions.

[104] See, eg, Melbourne Social Equity Institute, *Seclusion and Restraint Project: Overview* (2014) University of Melbourne.

Workers within mental health services

230 The use of restrictive interventions also poses a high risk of harm for staff. The MHCC acknowledges that in many if not most instances, staff are concerned about the use of restraint and seclusion and may experience distress during or following the use of restraint or seclusion.

Factors contributing to the use of restrictive practices in mental health services

231 An overarching factor contributing to the use of restraint and seclusion in mental health services is that most services have not implemented any frameworks of human rights, supported decision-making or trauma-informed care. Where attempts have been made to implement these frameworks, they are not well or consistently understood by all staff. One strategy to reduce the use of restraint and seclusion would be to foster a stronger understanding and better implementation of these frameworks. This could be achieved through staff training and system change through redesigning services in collaboration with consumers and families to be more trauma-informed. Services require support, leadership and additional resources to meaningfully implement these approaches.

232 Many consumers do not feel that they are routinely supported to make decisions about their treatment or that their human rights are considered as a core part of treatment. There are many reasons for this. One reason is that there is a lack of skills in and understanding of supported decision-making. Another reason is that the demands on services are currently extremely high, making it difficult for staff to spend adequate time getting to know consumers and their preferences.

Factors contributing to the use of restraint

233 Themes that arise from complaints to the MHCC in relation to the use of restraint suggest that the following factors contribute to the use of restraint in general:

(a) inadequate clinical engagement with consumers, including lack of explanation to the person about why they need medication, lack of exploration of medication options and alternatives, including the use of sensory tools (which may not be uniformly available);

(b) inadequate consideration of other less restrictive options to the use of restraint, such as the range of *Safewards* interventions or one-to-one "specialling" nursing of consumers;

(c) inadequate consideration of de-escalation strategies, for example, using restraint to prevent a person from absconding when there has been insufficient evidence of a discussion with the person about less restrictive options;

(d) insufficient consultation with families, carers and support people, including lack of exploration with the consumer's family, carer or support person about what strategies could be used to de-escalate difficult situations;

(e) reliance on a consumer's history, or a pre-conception that a person may present an occupational safety risk; and

(f) inconsistent decision-making (for example, inconsistent approaches to whether a person can leave the unit to have a cigarette can prompt challenging behaviour).

A higher risk of use of mechanical restraint in emergency departments

234 Complaints to the MHCC indicate a higher risk of the use of mechanical restraint (and especially prolonged restraint) in EDs. Based on the complaints received, we believe that four factors contribute to this.

235 First, EDs are not appropriate environments for people who are acutely unwell. The ED environment is characterised by noise, bright lights, lack of privacy, and "busyness". The small amount of space available in EDs and management of risk in that environment may also exacerbate people's distress and symptoms and limit their ability to use other coping mechanisms. Further, EDs provide services to many vulnerable people, including older people and children. Accordingly, most EDs have a low threshold for managing behavioural disturbance which can have significant impacts for people who are experiencing mental health issues.

236 Secondly, ED clinicians are often not aware of their responsibilities under the Act for people who are subject to a compulsory Treatment Order who are restrained. They may not have had any specialist training in relation to the treatment and care of mental health consumers, nor had the opportunity to develop skills in relation to therapeutic engagement or effective de-escalation strategies. Complaints to the MHCC have indicated that ED clinicians also do not usually have the time for therapeutic engagement or effective de-escalation strategies. Complaints about people's experiences in EDs have included instances where ED clinicians have concluded that they need to wait for a psychiatrist to assess the person before removing restraints. This has included complaints where services used prolonged restraint, even when a person is noted to be asleep and settled for a significant period.

237 Thirdly, the unavailability of beds means that people are often in prolonged restraint while waiting for a bed in the acute inpatient unit.

238 Fourthly, the risk of prolonged restraint appears to increase if the admission to ED occurs after hours.

Factors contributing to the use of seclusion

239 Similar factors contribute to the use of seclusion. In addition to the factors outlined above the contribute to the use of restraint, factors that contribute to the use of seclusion include:

(a) lack of amenity or alternative environmental options in acute inpatient environments, such as sensory rooms, "swing" rooms and doors to create flexible areas for safety,[105] choices of spaces to separate consumers, and suitable intensive care areas;

(b) capacity of services to effectively respond to the level of conflict and risk in closed environments, particularly for consumers with multiple and complex needs, substance affected or forensic histories; and

(c) poor understanding by staff of the circumstances in which seclusion can be lawfully used under the Act.

240 In an example of the last point, we have received complaints from consumers who believed they were placed in seclusion for reasons including being too noisy (singing and banging walls), or damaging property.

Use of standards, oversight and monitoring to drive a reduction in the use of restrictive practices

Increased sharing and public reporting of data

241 A number of agencies and bodies have responsibility for oversight and monitoring of the use of restrictive interventions. This includes the DHHS, Office of the Chief Psychiatrist, Victorian Agency for Health Information, and SCV, who all have a role to play in oversight or reporting of all instances of the use of restraint or seclusion, as well as the MHCC's oversight and safeguarding role in relation to complaints about the use of restraint and seclusion.

242 One way that these agencies could better support the reduction in the use of restrictive interventions is through more collaborative, transparent and regular sharing of data about the use of restrictive interventions. Currently, the rate of seclusion per 1000 bed days is reported publicly on the DHHS's website on a quarterly basis. We understand that the draft Performance and Accountability Framework under development by DHHS includes additional measures related to the use of restrictive interventions. The MHCC welcomes the inclusion of these measures.

[105] "Swing" rooms and doors can be used to create separate areas by closing off access of one side and creating a separate space or corridor.

243 The MHCC has advocated for serious incidents including sexual assaults to be included in service Statements of Priorities and publicly reported, to increase transparency and accountability for preventing these breaches of people's safety and rights. Public and transparent reporting of alleged physical assaults within mental health services, including alleged assaults that occur during the course of restraint or being placed in seclusion, would be equally beneficial.

244 We note that there are opportunities for people with lived experience to be more meaningfully involved in the development of reporting measures and reports produced by VAHI and SCV, in line with approaches in the department, mental health services and other statutory bodies including the MHCC and the Mental Health Tribunal. This is likely to have an additional benefit of developing reports that are useful and meaningful to consumers, families and carers and report on the things that matter to them and would drive improvements to treatment and care.

245 We have already begun to share complaints data and look forward to discussing with SCV and VAHI how our complaints data can inform and add value to other reports or monitoring and service improvement mechanisms, including the Inspire reports which have in the past included a focus on reducing restrictive interventions.

246 The MHCC has arrangements in place with the Office of the Chief Psychiatrist to seek information about the use of restrictive interventions (for example, to confirm whether an episode of restraint or seclusion that is the subject of a complaint was reported to the Chief Psychiatrist as required by s 108(1) of the Act).

Identification and monitoring of practices to reduce rates of use of restrictive interventions

247 Standards, monitoring and oversight are important for supporting a reduction in the use of restrictive interventions, and are critical to identifying where services may require additional strategies and changes in practices to reduce their use of restrictive interventions, including the implementation of trauma-informed care and supported decision making. Such oversight and monitoring however requires a strong human rights framework to lead to sustainable changes in practices and reduction of the use of restrictive interventions.

Local, national and international examples of "exemplary" approaches to reducing restrictive practices, and promoting the use of alternative strategies and practices

Supporting leadership within and across services to influence cultural change

248 A key factor in the reduction of the use of restrictive interventions is supporting cultural change within mental health services to create services that are human rights-based, trauma-informed and enable supported decision-making. There are existing structures

that are well placed to support cultural change and development within mental health services including the Victorian Mental Health Inter-professional Leadership Network (**VMHILN**), which has a vision:

> to be a thriving, influential and highly valued Network that actively leads change for recovery in local mental health services and broader policy reform to improve the experiences of all those who utilise or work within mental health services.[106]

A particular strength of the VMHILN is that the representatives of this network are interdisciplinary, with lived experience staff working alongside nurses, allied health and medical staff to create change.

249 As the VMHILN brings together staff from services across Victoria, it also provides a good opportunity for services to share the approaches they have used to reduce the use of restrictive interventions, which is a key part of creating broad cultural change across the system.

The Safewards program

250 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 in mental health services. Safewards uses a range of strategies to promote interactions between staff and consumers that are more positive. Safewards has also established a regular "mutual help" meeting with staff and people accessing inpatient treatment. This approach encourages staff to take a strengths-based perspective with regard to 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' practices (including seclusion and restraint).[107] This approach has now been expanded to EDs although its effectiveness in those environments is not yet known.

251 Safewards also supports the availability of sensory modulation tools. Wider availability of these tools in EDs, as well as in acute inpatient units, may assist in preventing the use of restrictive interventions. For this to work, either EDs would need to train staff in how to

[106] Victorian Mental Health Interprofessional Leadership Network (2020) <www.vmhiln.org.au>.
[107] L Bowers et al, 'Reducing Conflict and Containment Rates on Acute Psychiatric Wards: The Safewards Cluster Randomised Controlled Trial' (2015) 52 *International Journal of Nursing Studies* 1412; J Fletcher et al, 'Outcomes of the Victorian Safewards Trial in 13 Wards: Impact on Seclusion Rates and Fidelity Measurement' (2017) 26 *International Journal of Mental Health Nursing* 461.

offer and use these tools, or there must be trained staff available to attend EDs as required.

International examples

252 There are international examples of services that take different approaches to care provision that do not involve the use of restrictive practice. These international examples include peer-developed and peer-led services. One example is Tupu Ake, a peer-led acute alternative service in New Zealand that has been operating for over 10 years. Tupu Ake has been shown to be effective in reducing the distress of the people who access the service (called "guests"). Both guests and clinical mental health service providers viewed Tupi Ake as a valuable part of the service system.[108]

253 There are also international examples of the way in which the independent OPCAT inspection visits of mental health services have been used as a driver to reduce restrictive practices. Such visits can reduce the use of restrictive practices by highlighting the ways in which such practices are experienced as "cruel, inhuman or degrading" and contrary to the human rights obligations under this UN convention.[109]

Workforce capability, practice and oversight

Weaknesses and limitations of existing oversight mechanisms for the mental health workforce (including conduct, quality and practice)

254 There are gaps in the existing mechanisms to oversee the professional practice and conduct of the mental health workforces. This is because some clinicians and support workers are not covered by AHPRA. Examples of those not covered are social workers and peer workers.

255 The MHCC has made referrals to AHPRA on issues raised or identified in complaints about alleged or potential misconduct and poor professional practice of mental health clinicians. In some of these matters, the MHCC has questioned the extent to which the service supported the consumer to provide the account of their experience, and the thresholds used to determine whether regulatory action was warranted.

256 The efficacy of investigations by AHPRA can also be affected by time delays caused by awaiting the outcome of investigations undertaken by services, and the nature of evidence that can be obtained once interviews have already been conducted. In the MHCC's experience, services are not the best placed to undertake investigations of

[108] See Te Pou o te Whakaaro Nui, 'Evaluation of Tupu Ake: A Peer-led Acute Alternative Mental Health Service', (October 2017) <www.tepou.co.nz>.
[109] See references in Lynne Coulson Barr, 'Australian Perspectives on OPCAT' (Speech delivered at Towards Eliminating Restrictive Practices: Twelfth National Forum, Hobart, 8 November 2018) <http://www.terpforum.com/>.

serious allegations due to the limitations in their powers and capacity to obtain and properly test the evidence, and can lead to the available evidence being compromised.

257 Workforce shortages in some areas, particularly rural areas, create risks for consumers particularly where there is a high use of poorly trained agency staff to fill roster gaps or where some positions are unable to be filled for long periods of time, particularly specialised positions including medical staff.

258 We acknowledge that there are strengths and weakness across all groups of the mental health workforce. However, some sections of the workforce, having previously worked within an institutional model, may not have adapted to be fully competent in contemporary approaches to mental health nursing. Contemporary approaches include dealing with challenging behaviour using non-coercive methods and de-escalation strategies, and adopting a person-centred and recovery framework as part of therapeutic engagement.[110] Entrenched institutional cultures not only create risks for consumers, they make it difficult for staff trained in approaches that are more contemporary to be effective in their work.

259 A positive outcome of the establishment of the MHCC has been the ability to identify and make recommendations about areas of weakness in practice where these weaknesses appear to exist across a service, rather than being limited to an individual. A common outcome of complaints to the MHCC is staff training in the particular issue or area of practice identified in the complaint. These include areas of foundational requirements such as training in the requirements of the Act, for instance in relation to the making of an Assessment Order, authorisation and reporting of restrictive interventions, trauma-informed care, family-inclusive practice, and gender-sensitive and safe practice.

260 Investigations by the MHCC have identified issues in new staff, as well as agency staff, receiving adequate induction into service policies and the requirements of the Act, along with limited opportunities for staff to access ongoing professional and skill development in key areas of practice, such as trauma informed care or meeting the needs of people with a dual disability.

261 The recent establishment of the Centre for Mental Health Learning (**CMHL**) is a positive step to create some statewide consistency in training in foundational areas of practice, including legislative requirements. We have recently commenced regular meetings with the CMHL to share our learnings from complaints to help to inform their work program and prioritisation of particular areas of learning and development. We note that it is also important that the learning and development programs be informed by the observations

[110] See, eg, Office of the Chief Mental Health Nurse, 'Mental Health Intensive Care Framework', (December 2019) DHHS <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-intensive-care-framework>.

of other agencies including the community visitors program operated by the Public Advocate, Mental Health Tribunal, IMHA, VMIAC and Tandem.

Potential oversight implications of a significant expansion and diversification of the workforce

262 The regulatory framework for workers will need to be considered, as an expanded and diversified workforce will mean that there are likely to be more workers who are not registered health practitioners with AHPRA, such as peer workers and social workers. There will be implications for the interface with the jurisdiction of the HCC for unregistered health providers and with the Victorian Disability Worker Scheme for workers who provide psychosocial support services and peer support.

263 There are oversight implications of an expanded and diverse workforce providing services in a range of settings. These implications include:

(a) the need for clear models of care and expectations on the nature of services provided; and

(b) safeguards such as clinical governance and accessible complaint mechanisms for consumers, families and carers.

264 The capabilities, skills and training needs of an expanded workforce will also need to be considered.

Potential oversight implications of a greater use of digital technologies by staff to provide mental health services

265 The MHCC has provided input to the work being done on standards for digital mental health services, highlighting the need for safeguards and accessible complaint mechanisms.

266 Greater use of digital technologies by staff will require consideration of:

(a) appropriate skills and supervision of staff;

(b) privacy and confidentiality of information; and

(c) potentially new formats for clinical records and storage of information.

267 Where complaints or allegations are made in relation to the conduct of staff or nature of treatment, it is important there are appropriate forms of clinical records available. Records might need to be examined as part of an investigation. The availability of records is necessary in order to provide a fair process for both the consumer and the clinician or service.

Forensic mental health

Complaints from consumers receiving mental health treatment in forensic settings

268 The MHCC can deal with complaints from consumers receiving mental health treatment in forensic settings where services are provided by Designated Mental Health Services (which represents a small proportion only of the mental health care provided in prisons), including Thomas Embling Hospital and Forensicare's community mental health services.

269 The following issues were the most commonly raised issues in complaints made to the MHCC by or in relation to consumers receiving mental health treatment in forensic settings in the period between 1 July 2014 and 30 June 2019:

(a) delay in treatment (96 complaints, or 19% of all complaints about forensic settings, compared to 5% of complaints overall);

(b) refusal to prescribe or dispense medication (85 complaints, 17% of all complaints about forensic settings, compared to 3% of complaints overall);[111]

(c) inadequate, incomplete or confusing information (65 complaints, 13% of all complaints about forensic settings, compared to 14% of complaints overall);

(d) inadequate consideration of the views and preferences of the consumer (64 complaints, 13% of all complaints about forensic settings, compared to 17% of complaints overall); and

(e) dissatisfaction with changes to prescribed medication (49 complaints, 10% of all complaints about forensic settings, compared to 4% of complaints overall).[112]

270 Complaints about forensic settings rose during the first four years of the MHCC's operation, peaking in 2017–18 when they accounted for 10% of all complaints, before decreasing to 5% of all complaints in 2018–19. The proportions of complaints raising the above issues rose and fell in a similar fashion.

271 The MHCC has dealt with two significant cases in forensic settings (of "civil" patients not subject to custodial orders) where the person has been secluded for extensive periods. These complaints raised significant questions about *Charter* rights and compliance with the requirements and principles of the Act, and highlighted the particular challenges of meeting the needs of consumers with multiple and complex needs in forensic settings. As an outcome of one of these complaints, the MHCC identified the need for the Department to 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

[111] We note that it is common practice for prisons not to prescribe or dispense certain mental health medications that are assessed as being at high risk of misuse within a custodial environment, and this is a reason for the much higher rate of complaints about these issues in forensic settings.
[112] See above n 111.

facilities or are subject to prolonged use of restrictive interventions. That complaint led to a range of actions being taken by both the service and the Department in response to recommendations made by the MHCC to address these significant issues and risks in forensic settings.

sign here ►

print name Lynne Coulson Barr

date 4 June 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT LCB-1

This is the attachment marked "LCB-1" referred to in the witness statement of Lynne Coulson Barr dated 4 June 2020.

Curriculum Vitae

DR LYNNE COULSON BARR OAM

CURRENT POSITION

COMMISSIONER

MENTAL HEALTH COMPLAINTS COMMISSIONER, VICTORIA

Appointed as the inaugural Mental Health Complaints Commissioner on 28 April 2014.

EDUCATION

DOCTOR OF JURIDICAL SCIENCE (LAW) 2016
Monash University

MASTER OF SOCIAL WORK (HIGH DISTINCTION) 1995
Monash University

BACHELOR OF SOCIAL WORK (HONOURS) 1980
Monash University

BACHELOR OF ARTS (SOCIOLOGY MAJOR) 1978
Monash University

OTHER QUALIFICATIONS

COMPANY DIRECTORS COURSE 2020
Australian Institute of Company Directors

ACCREDITED MEDIATOR & CONCILIATOR 2006-2016
National Mediator Accreditation Scheme (2012); Institute of Arbitrators and Mediators Australia (2006)

AWARDS & FELLOWSHIPS

WEINSTEIN INTERNATIONAL FELLOWSHIP 2013
One of 12 global applicants selected by the JAMS Foundation to undertake an international fellowship program on approaches to alternative dispute resolution (ADR) in the United States.

VICTORIAN HONOUR ROLL OF WOMEN 2014
One of 20 women inducted into the Victorian Honour Roll of Women in 2014 in recognition of significant contribution to social justice in the Victorian community.

SENIOR FELLOW, WEINSTEIN INTERNATIONAL FOUNDATION 2018
Appointment in a voluntary capacity to a non-profit organisation dedicated to making mediation and dispute resolution available and accessible worldwide.

TOP 50 PUBLIC SECTOR WOMEN VICTORIA 2018
Awarded by Institute of Public Administration Association Victoria

MEDAL OF THE ORDER OF AUSTRALIA 2020
Awarded for significant service to community mental health and roles in disability, dispute resolution and tribunals.

PREVIOUS COMMISSIONER/STATUTORY HEAD ROLES

COMMISSIONER (ACTING): DISABILITY SERVICES COMMISSIONER, VICTORIA
5 April 2018 to 4 August 2018

DEPUTY COMMISSIONER: DISABILITY SERVICES COMMISSIONER, VICTORIA
2 July 2007 to 27 April 2014

PRESIDENT: INTELLECTUAL DISABILITY REVIEW PANEL, VICTORIA
10 August 2004- 30 June 2007

TRIBUNAL POSITIONS (1997-2017)- SESSIONAL
STATE AND COMMONWEALTH STATUTORY APPOINTMENTS

ADMINISTRATIVE APPEALS TRIBUNAL (COMMONWEALTH)
NDIS Specialist Division
August 2013- July 2017

MENTAL HEALTH REVIEW BOARD (VICTORIA)
June 2003- April 2014

VICTORIAN CIVIL & ADMINSTRATIVE TRIBUNAL (VICTORIA)
June 2004- April 2014

SUITABILITY PANEL (VICTORIA)
May 2007- April 2014

SOCIAL SECURITY APPEALS TRIBUNAL (COMMONWEALTH)
October 1997- June 2007

ACCREDITATION DECISIONS REVIEW COMMITTEE (COMMONWEALTH)
June 2000- October 2011

INTELLECTUAL DISABILITY REVIEW PANEL (VICTORIA)
March 1999- 9 August 2004

VICTORIAN INSTITUTE OF TEACHING (VICTORIA)
November 2003- December 2006

MULTIPLE & COMPLEX NEEDS PANEL (VICTORIA)
June 2007 - May 2009

CONSULTANCY AND RESEARCH (1997- 2007)

Contracts included: Production of successful tenders and submissions for non-government agencies for new programs and services; research projects; discussion papers; development and delivery of pilot programs; program evaluations; strategic plans.

SUMMARY OF PREVIOUS EMPLOYMENT HISTORY: COMMUNITY SECTOR LEADERSHIP AND MANAGEMENT ROLES (1980 to 1996)

COPELEN CHILD AND FAMILY SERVICES
Deputy Director I General Manager Client Services: Feb 1994-May 1996

OZ CHILD - FOSTERCARE WESTERNPORT
Principal Officer I Program Manager: May 1993-Feb 1994

FOCUS FOSTERCARE
Project officer: Mar 1993- Apr 1993

KENT COUNTY COUNCIL, UNITED KINGDOM
Senior Practitioner, Gravesend Children & Families Team: Apr 1992- Jan 1993

COMMUNITY SERVICES OF VICTORIA, SOUTHERN REGION:
Senior Child Protection Worker: Oct -Nov 1990

FOCUS FOSTERCARE
Project officer: Dec 1989- Sept 1990

LIFELINE, WESLEY CENTRAL MISSION
Deputy Director: Feb 1987- Dec 1989

FOCUS FOSTERCARE
Principal Officer: June 1983- Oct 1986

INNER URBAN CHILDREN AND YOUTH SERVICES COMMITTEE
Consultant/Research Officer: Nov 1882- Apr 1983

VICTORIAN ABORIGINAL CHILD CARE AGENCY
Social Worker / Foster care Consultant: Dec 1980 - June 1982

CURRENT MEMBERSHIPS AND AFFILATIONS

AUSTRALIAN INSTITUTE OF COMPANY DIRECTORS (AICD)

AUSTRALIAN AND NEW ZEALAND SCHOOL OF GOVERNMENT (ANZSOG)- Regulators Community of Practice Group

AUSTRALIAN AND NEW ZEALAND MENTAL HEALTH ASSOCIATION

AUSTRALIAN AND NEW ZEALAND HEALTH COMPLAINTS AND DISABILITY COMMISSIONERS GROUP

AUSTRALIAN AND NEW ZEALAND MENTAL HEALTH COMMISSIONERS GROUP

INSTITUTE OF PUBLIC ADMINISTRATION ASSOCIATION (IPAA)

INTERNATIONAL INITIATIVE IN MENTAL HEALTH LEADERSHIP (IIMHL)

RESOLUTION INSTITUTE (Professional Dispute Resolution Membership Association- formerly LEADR & IAMA)

UNITED NATIONS 2020 DECADE OF PEACE INITIATIVE- Founding Member through participation in the International Peace Congress hosted by Mediators without Borders and Rotary International Nov 2019

VICTORIAN ASSOCIATION FOR DISPUTE RESOLUTION

VICTORIAN HONOUR ROLL OF WOMEN AMBASSADORS GROUP

WEINSTEIN INTERNATIONAL FOUNDATION- Senior Fellow

PUBLICATIONS

Coulson Barr, Lynne 'People's right to have to their medical and other health and disability needs recognised and responded to by mental health services', in Equally *Well in Action: Implementing strategies to improve the physical health of people living with mental illness. Proceedings of the First*

National Equally Well Symposium, RMIT, Melbourne, Vic. March 2019: Charles Sturt University; 2019.

Coulson Barr, Lynne, '*Australian Perspectives on OPCAT'*- The implications of Australia's ratification of United Nations' Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Paper presented at the12th National Forum on 'Towards Eliminating Restrictive Practices 2018)

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

Coulson Barr, Lynne 'Safeguarding rights, upholding the mental health principles and empowering consumers and carers across Victoria' *New Paradigm Winter 2017* The Australian Journal on Psychosocial Rehabilitation 2017

Coulson Barr, Lynne *Decision making on the suitability of disputes of statutory conciliation: enabling appropriate access, particularly for people with disabilities.* 2016 Doctoral Thesis Monash University

Coulson Barr, Lynne, '*Coach, Compliance Officer or Peace Maker: Responding to Expectations and Practice Issues in Statutory ADR'* (Paper presented at the 12th National Mediation Conference, Melbourne, 11 September 2014)

Coulson Barr, Lynne, '*Unlocking the Door: Rethinking Approaches to Determining the Suitability of Disputes for Conciliation'* (Paper presented at the 11th National Mediation Conference, Sydney, 13 September 2012)

Coulson Barr, Lynne *Safeguarding People's Right to be Free from Abuse: Key considerations for preventing and responding to alleged staff to client abuse in disability services.* Disability Services Commissioner June 2012

Coulson Barr, Lynne, '*Finding the Right Key: Unlocking Approaches to Making Decisions about Suitability of Disputes for Conciliation. A Focus on Access for People with a Disability* (Paper presented at the 10th National Mediation Conference, Adelaide, 9 September 2010)

Coulson Barr, Lynne & Nihill, Genevieve, 'Disability and Discrimination: Intellectual Disability' *The Law Handbook 2007* Ch 16.5, Fitzroy Legal Service 2007

Coulson Barr, Lynne *Safe party: A guide to delivering a safe party program in your school or community* (2002) Melbourne: Australian Drug Foundation

Royal Commission into
Victoria's Mental Health System

ATTACHMENT LCB-2

This is the attachment marked "LCB-2" referred to in the witness statement of Lynne Coulson Barr dated 4 June 2020.

Acronyms and abbreviations	
ACQSHC	Australian Commission for Quality and Safety in Health Care
AHPRA	Australian Health Practitioner Regulation Agency
CIMS	Client Incident Management System
CMHL	Centre for Mental Health Learning
CPAP/BIPAP	Continuous Positive Airway Pressure/Bilevel Positive Airway Pressure
DHHS	Department of Health and Human Services
DSC	Disability Services Commissioner
ED	emergency department
HCC	Health Complaints Commissioner
IMHA	Independent Mental Health Advocacy
MHCC	Mental Health Complaints Commissioner
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme

Acronyms and abbreviations	
NSQDMH	National Safety and Quality Digital Mental Health
OPCAT	*Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*
SCV	Safer Care Victoria
VAHI	Victorian Agency for Health Information
VCAT	Victorian Civil and Administrative Tribunal
VHIMS2	Victorian Health Incident Management System
VMHILN	Victorian Mental Health Inter-professional Leadership Network
VMIAC	Victorian Mental Illness Awareness Council

Royal Commission into Victoria's Mental Health System

ATTACHMENT LCB-3

This is the attachment marked "LCB-3" referred to in the witness statement of Lynne Coulson Barr dated 4 June 2020.

MHCC complaints data: Issues about physical health, mobility and other needs of consumers of mental health services

The mental health principles of the Act state 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 also clearly critical for people's mental health, wellbeing and recovery.

As noted in paragraph 47(a) of this witness statement, complaints about failure of mental health services to meet the physical needs of consumers are relatively frequent. Between 1 July 2014 and 30 June 2019, 210 complaints were raised about this issue. The proportion of all complaints to the MHCC about this issue has increased from 1% in 2014-15 to 7% in 2018-19. In addition, 10 complaints were received in relation to mobility aides, and six in relation to medical devices during this period.

The MHCC's submission to the Royal Commission in July 2019 outlined a number of specific issues in complaints about physical health and disability needs not being met, including:

- Failure to diagnose, monitor and/or treat a range of health conditions, including musculoskeletal, coronary, dental, respiratory or urinary tract conditions; failure to review or refer, and delays in access to diagnostic test results
- Lack of access to pain medication, and lack of consideration of interactions between pain medication and psychiatric medication
- Lack of staff knowledge or difficulties using CPAP/BIPAP devices or nasogastric tubes
- Lack of mobility devices for consumers with pre-existing injuries and disabilities
- Delays or inadequate treatment for injuries sustained during mechanical or physical restraint or assaults by other patients, other injuries sustained on inpatient units or injuries sustained during the circumstances that led to the consumer's admission
- Lack of attention to the specific health needs of female consumers, including the effects of psychiatric medication on potential pregnancies, and ensuring access to lactation supports and pregnancy/STI tests

Since the MHCC's submission to the Royal Commission, the MHCC has received 51 additional complaints about services' failure to meet the physical health needs of consumers. Specific issues raised in these complaints have included:

- Failure to diagnose and treat existing medical conditions such as dental issues, infections and broken bones, and to respond quickly to existing medical conditions requiring urgent attention
- Delays in receiving consultations with medical practitioners, podiatrists, and occupational therapists, or failure to make referrals
- Lack of or delays in provision or administration of medication including pain medication and antibiotics
- Delays in providing consumers with access to medical results including blood tests and documentation including medical certificates
- Failure to consider existing long term physical medical conditions when assessing and treating mental health including diabetes and fibromyalgia, and lack of regular testing including blood testing for consumers with pre-existing conditions such as a vitamin B deficiency

- Failure to consider the physical health side effects of medication when treating mental health
- Removal of personal medication including Ventolin and Spiriva, restricting the consumer's ability to self-administer required medication
- Lack of provision of physical aids including reading glasses, hearing aids and dentures
- Lack of support and follow-up following a discharge, and continuity of care
- Further instances of delayed or inadequate care after sustaining injuries while admitted to inpatient units and lack of subsequent access to therapeutic treatment including physical therapy for broken bones
- Ongoing lack of responsiveness to the specific health needs of female consumers including testing for pregnancy

Royal Commission into Victoria's Mental Health System

ATTACHMENT LCB-4

This is the attachment marked "LCB-4" referred to in the witness statement of Lynne Coulson Barr dated 4 June 2020.

MHCC Complaints data: Issues about alleged physical assaults on consumers

One of the mental health principles outlined in the Act prescribes that people receiving mental health services should be provided with those services with the aim of bringing about the best therapeutic outcomes. Services also have an obligation to provide a safe environment and uphold people's human rights under the Charter. For a consumer to experience alleged physical assault from either staff or other consumers during an episode of care is highly traumatic, detrimental to recovery and often leads to a reluctance to seek treatment in future.

As noted on paragraph 51 of this witness statement, 119 complaints (2% of all complaints) were received from 1 July 2014 to 30 June 2019 about alleged physical assaults by staff. This included 83 (1%) complaints about alleged physical assaults by clinical staff, and 38 (1%) complaints about alleged physical assaults by security staff. Also noted in paragraph 51 was that 82 (1%) complaints have been received in this period about alleged physical assaults by consumers or others. The vast majority of these complaints – 79 (1%) have been about alleged physical assaults by consumers, with the remaining three about alleged physical assaults by visitors or others.

Specific issues raised in recent complaints about these issues have included:

- Alleged physical assaults by clinical and security staff often relate to the alleged use of excessive force when using bodily restraint, placing consumers in seclusion or conducting searches of consumers or their belongings. Some of these issues, particularly with regard to the use of force when using bodily restraint, are discussed in more detail at paragraphs 216-224 of this statement.
- Alleged physical assaults by other consumers, including consumers being grabbed, hit unprovoked and unaware, kicked, and hit with objects in bedrooms and shared areas
- Failure to provide a physically and therapeutically safe environment, including identifying consumers that may be at risk of causing harm to others and adequately managing identified risks, or identifying and taking action in response to allegations against staff
- Failure to remove dangerous items from consumers, including knives, and monitor the use of items that may cause potential harm such as hot beverages
- Inadequate follow up response and treatment for injuries sustained during alleged assaults by staff and other consumers
- Inadequate acknowledgement of alleged assaults by staff and co-consumers following feedback, and lack of tangible outcomes including a change in restraint practices and treatment of consumers
- Failure of security and clinical staff to use the least restrictive methods while restraining consumers, resulting in consumers sustaining physical injuries

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Royal Commission into Victoria's Mental Health System

ATTACHMENT LCB-5

This is the attachment marked "LCB-5" referred to in the witness statement of Lynne Coulson Barr dated 4 June 2020.

MHCC complaints data: Issues related to supported decision making

The Act outlines that people receiving mental health services should be involved in all decisions about their assessment, treatment and recovery, and be supported to make, or participate in, those decisions, and their views and preferences should be respected. However, complaints to the MHCC indicate significant issues and gaps in the extent to which services' approaches reflect this principle. Many consumers report not feeling that their views and preferences have been considered as part of decision making. Reasons for this include a lack of skills in and understanding of supported decision making, and high levels of demand on services, making it difficult for staff to spend adequate time getting to know consumers and their preferences, explaining treatment options and answering questions.

The MHCC also receives complaints that are specifically about how the supported decision-making mechanisms of the Act are operating, including complaints about advance statements and nominated persons in decision making, and access to second psychiatric opinions. The issues raised in these complaints are discussed in detail at paragraphs 203 to 208 of this statement. This attachment focuses on describing the issues that are most commonly raised in conjunction with concerns about a consumer's views and preferences not being considered, as well as noting the kinds of experiences that may prevent people from feeling genuinely able and safe to engage in supported decision making. These experiences need to be addressed in order for people to truly experience supported decision-making when accessing mental health services.

Barriers to supported decision making

Some of the issues raised frequently in association with inadequate consideration of the views and preferences of consumers describe the barriers people experience to engaging in supported decision making. For example, 13% of complaints raised in conjunction with 'views and preferences not considered' included issues relating to rudeness / lack of empathy, which includes experiencing a lack of respect or courtesy, lack of compassion and being ignored or unattended to. Similarly, 13% of complaints that included a concern that a consumer's views and preferences were not considered also noted that information provided was inadequate, incomplete or confusing. Complaints were also raised about gender-unsafe or generally unsafe environments, and about discrimination on a range of grounds. Taken together, these experiences are all likely to contribute to feelings of lack of safety, fear, or lack of trust in the service. If a person is not experiencing these then supported decision making cannot occur.

Overview of complaints about inadequate consideration of views and preferences of consumers that relate to supported decision making

1,208 complaints made to the MHCC from July 2014 to June 2019 raised the issue of services' inadequate consideration of the views and preferences of consumers. This issue was raised in 17% of all complaints raised during this time period, making it the most frequently raised Level 3 issue in complaints to the MHCC.

Individual Level 3 issues (the most detailed description of the particular issue reported by the person making the complaint) that are commonly raised alongside 'inadequate consideration of the views and preferences of consumers' include:

- Disagreement with treatment order (15% of all complaints that had inadequate consideration of the views and preferences of consumers as an issue)
- Side-effects from medication (14%)
- Lack of care / attention, e.g. not feeling listened to / believed (8%)
- Dissatisfaction with prescribed medication (7%)
- Leave concerns (6%)
- Least restrictive option not considered (6%)
- Inadequate consideration of the views of families and carers (5%)
- Unnecessary medication (4%)
- Preference for oral over depot medication (4%)
- Inadequate therapeutic options (3%)
- Voluntary patients feeling they must accept treatment / threat of compulsory treatment (2%)
- Over-sedation (2%)
- Lack of trauma informed care (1%)
- Inadequate supports to enable supported decision making (1%)

Themes arising in complaints about inadequate consideration of views and preferences of consumers that relate to supported decision-making

The Level 3 issues that co-occur in complaints about inadequate consideration of the views and preferences of consumers and relate to supported decision-making form part of the following Level 2 issues categories:

- suboptimal treatment
- medication issues
- responsiveness of staff.

Accordingly, these issues are described below according to these groupings.

Suboptimal treatment

Issues relating to suboptimal treatment that reflect a lack of supported decision making include the disagreement with treatment orders, least restrictive option not being considered, leave concerns, inadequate therapeutic options, voluntary patients feeling like they must accept treatment, inadequate supports to enable supported decision making, and a lack of trauma informed care.

Specific issues raised in complaints recently received about suboptimal treatment issues included:

- Consumers believing that they do not meet the criteria under the Act for assessment or treatment orders, including that they have a mental illness in need of treatment
- Consumers wanting treatment orders revoked and to be discharged from services
- Consumers receiving inpatient treatment when they feel they could be treated in the community, or receiving inpatient treatment for longer durations than necessary
- Consumers being admitted to hospital for assessment, when they feel they could be assessed in the community. This includes instances where assessment in the community did not appear to have been considered as an option
- Consumers receiving compulsory treatment when they considered that they could be treated voluntarily by the designated mental health service or by seeking treatment from a private mental health service
- Consumers being placed in intensive care areas or high dependency units instead of less restrictive areas of the inpatient unit despite expressed preferences, including preferences that relate to fear or feelings of lack of safety in intensive care areas
- Consumers being required to take medication rather than be treated with other therapies, with limited or no access to other therapeutic options including psychological interventions
- Restrictions on consumers' travel within Victoria

- Consumers being voluntary patients, but feeling unsure of their status and feeling forced to take medication
- Consumers stating they have been told they would be readmitted or placed on assessment orders if they did not take their medication while voluntary patients
- Consumers stating they have been told they will be placed on an assessment order if they choose to discharge themselves from inpatient units while voluntary patients[113]
- Consumers being prevented from leaving the emergency department, despite attending voluntarily
- Consumers not being allowed leave the hospital, including for medical procedures, court proceedings, social security appointments, job interviews and to seek accommodation, and lack of explanation for why leave was not allowed
- Delays in being allowed leave, being provided with inconsistent information about leave, or cancellation of leave for inadequate reasons or without explanation
- Limited periods of leave, including for exercise and for cigarette breaks
- Lack of access to psychosocial interventions, such as cognitive-behaviour therapy, mindfulness, trauma-informed therapy, sexual assault counselling and social or community workers, and lack of recovery-oriented care
- Lack of access to trauma-informed care on inpatient units
- Inadequate consideration of or responses to grief, loss or trauma histories of consumers in diagnosis or treatment planning, to take such histories in a sensitive manner, to believe consumers or to create a safe space for consumers to disclose past trauma
- Failure of staff to provide contact details for services that can support or advocate for consumers.

Medication issues

Issues relating to medication that may relate to a lack of supported decision making include side effects from medication, dissatisfaction with prescribed medication, unnecessary medication, a preference for oral over depot medication, and over sedation.

Specific issues raised in complaints recently received about medication issues included:

- Consumers reporting a range of side effects of medication, including drowsiness, nausea, muscle weakness, muscle spasms, restlessness, anticholinergic effects, metabolic effects, gastrointestinal symptoms, headaches, seizures, dizziness, weight gain, insomnia, lack of motivation and suicidal thoughts
- Consumers reporting that services are not working with them to address side effects of medication, including services increasing the dosage of medications after consumers raised concerns
- Consumers reporting that the medication prescribed was unnecessary, including where consumers believed medication had been prescribed for behavioural rather than therapeutic reasons
- Services changing consumers' medication or dosage without consulting with the consumer or their families or carers, or providing any explanation as to why this was necessary
- Consumers preferring to be on different medications to what they are being prescribed, and reporting that services have not responded collaboratively to their requests or wishes
- Consumers preferring oral medications over depot medications
- Consumers being unable to afford prescribed medications, and reporting that services are not working with them to find suitable alternatives

[113] This has significant impacts for consumers, who must then decide either to remain a voluntary patient but be unable to leave the unit, without the oversight that occurs for a compulsory patient, or attempt to discharge themselves and be placed on a compulsory order.

Responsiveness of staff

Issues relating to responsiveness of staff that impact on supported decision making include:

- A lack of care or attention to consumers e.g. consumers not feeling listened to or believed
- Inadequate consideration of the views of carers, families and guardians

Specific issues raised in complaints recently received about responsiveness of staff included:

- Consumers not feeling listened to when reporting on their symptoms and experiences, leading to unwanted treatment
- Consumers believing that clinicians are relying solely on clinical records rather than consumers' accounts about their experiences
- Clinical staff not considering collateral information, including from family members or carers, or other explanations when offered
- Clinical staff not believing that consumers will or have taken their medication, or hearing consumers' concerns about side-effects of medication
- Consumers feeling not believed when disclosing past experiences, including trauma and abuse
- Services not contacting or organising meetings with families or carers, not involving them in discussions at meetings or organising them at inconvenient times
- Failure of services to consult with families or carers as part of assessment, or before changing medications or discharging consumers
- Inadequate consideration by services of family members' or carers' perceptions of risk of consumers to themselves or others