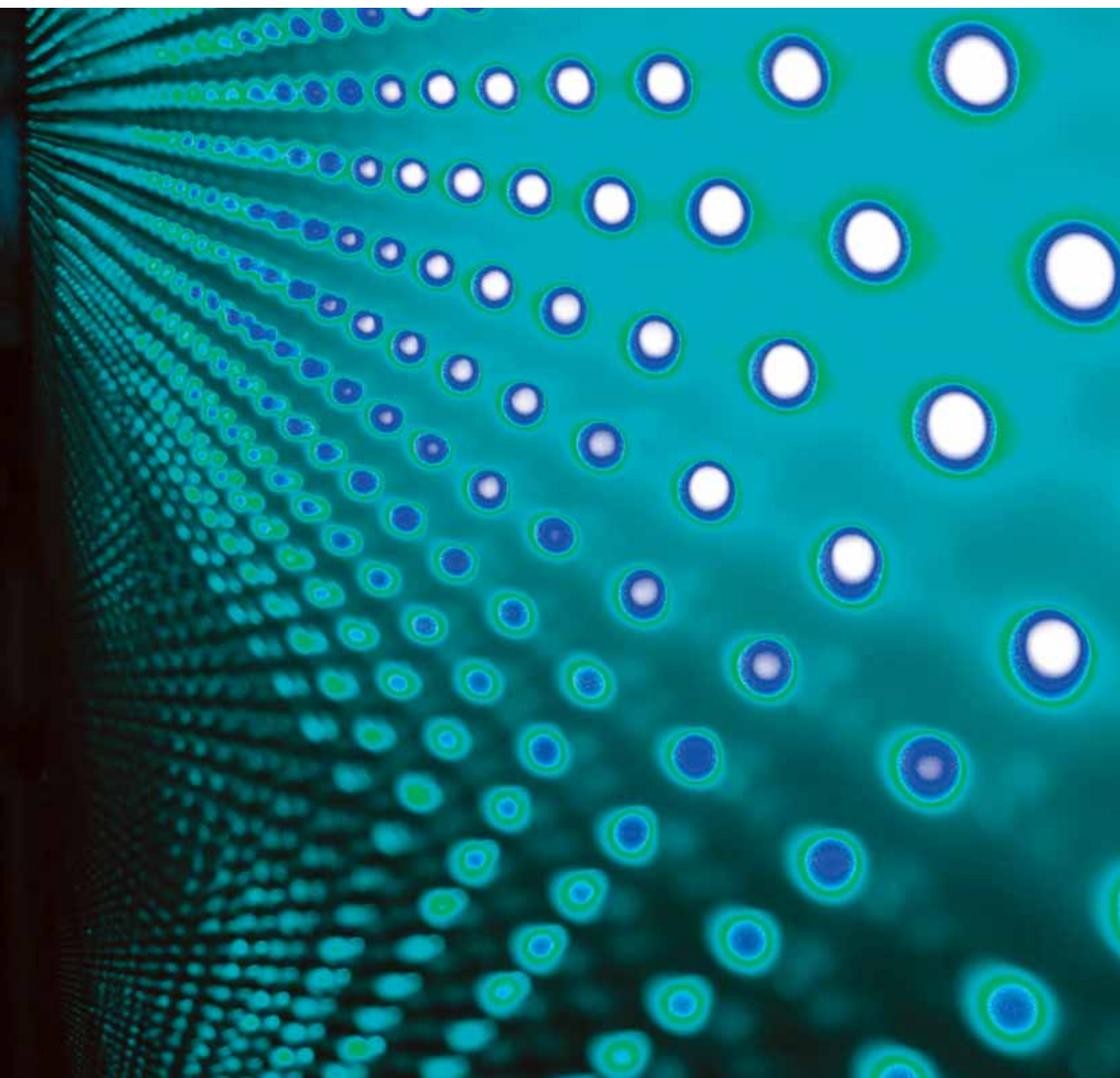


Mental Health Complaints Review Project

A report on the management of complaints processes
within selected mental health services in Victoria





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Issues and recommendations





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Foreword

In Victoria, public mental health services are organised in such a way that consumers have no choice of service. While there are positive reasons for this in terms of continuity of care, it also means that Victorians are unable to choose their service in the way they can for other health services, placing the onus on services to respond with particular care to consumer concerns. In addition, legislative provisions for involuntary treatment oblige services to ensure that adequate complaints processes are in place to safeguard the rights of people who are mentally ill.

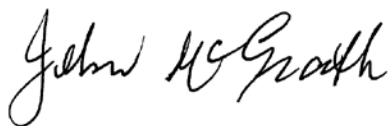
Notwithstanding the above, a complaint allows us to better understand the experience of a person in treatment, care or support.

Complaints allow services to hear accounts of the negative experience of consumers in care and that of their carers. Complaints processes provide services with an opportunity to improve their practices and to strive for ongoing improvement.

Complaints offer consumers and carers an opportunity to be heard. A good complaints system allows for reparation by way of a service's commitment to improve the experience of care for the complainant and those who follow.

The Mental Health Complaints Review Project has highlighted examples of good practice and many areas that require improvement. Significantly, it found that consumers and carers believe that making a complaint will adversely impact on the care and treatment they receive and in some instances this belief has been well founded. However, with the commitment of consumers, carers and mental health staff, I am confident that we can continue to strengthen the complaints management system.

I am pleased to present this report as we strive to improve and to provide a responsive system of mental health care for all.



John McGrath AM
Chair
Mental Health Complaints Review Project

1. Executive summary

Robust complaints management systems in mental health services help safeguard the rights of people who are mentally ill and are a fundamental feature of most modern mental health laws.¹ They also provide an opportunity for organisations to improve the quality of services, reduce the risk of complaints and support consumer and carer engagement and participation. Effective complaints management systems demonstrate a commitment to listening to, and including, the voices of consumers and carers in the review and improvement of mental health services.

In Victorian public mental health services, anecdotal evidence indicates that the complaints management system is characterised by complexity, variability in practice and a tendency for complaints to be escalated to external bodies without an attempt at local resolution.

In response, the Ministerial Advisory Committee, through its consumer and carer subcommittee, undertook the Mental Health Complaints Review Project in 2008 to review the complaints management processes in selected mental health services. The context for this project includes the current review of the *Mental Health Act 1986* and the requirement that public sector services be compliant with the *Charter of Human Rights and Responsibilities Act 2006*. Accordingly, the project is limited to improvements in policy development and local processes in complaints management. While the scope of the review has been limited to local mental health complaints processes, the subcommittee notes the benefits of establishing an independent complaints body, such as a mental health ombudsman.

The project produced 19 findings that confirmed and augmented the anecdotal evidence. The key themes identified include the need for greater:

- consumer and carer accessibility to complaints mechanisms
- service responsiveness to consumer and carer complaints
- transparency and accountability of the processes by which complaints are identified and managed.

In formulating the recommendations, the consumer and carer subcommittee considered issues in the context of ethics and human rights, governance, quality assurance, the role of organisational culture and a commitment to the fundamental principle of consumer and carer participation in treatment and care.

These considerations have been articulated in a vision statement.

¹ World Health Organization, 2005, *WHO Resource Book on Mental Health, Human Rights and Legislation*, WHO, Geneva, p.67.

Vision statement:

The mental health service complaints system will ensure that the human rights of consumers and carers are upheld through a complaints system that is respectful, accessible, responsive, accountable and transparent. It will provide for genuine participation of consumers and carers in the development, implementation and review of the system, incorporate sound governance, enable advocacy and recourse to independent complaints mechanisms.

To support the attainment of this vision, the subcommittee for consumers and carers presents the following recommendations.

That the minister:

Approve the development and implementation of a Victorian public mental health services complaints management framework.

Recommendation 1: Develop a Victorian public mental health services complaints management framework.

The proposed framework will be consistently and flexibly applied to respond appropriately to diverse communities, embedding greater accountability at board and executive level. It will incorporate a requirement to review and report to the Department of Human Services and the Minister on trends, issues and service outcomes. The framework will promote a learning culture where complaints are perceived and used as an opportunity to improve service. Most importantly, it seeks to strengthen current practices.

Ensure the genuine participation of consumers and carers in the development, implementation and review of the proposed Victorian mental health complaints management framework in collaboration with mental health services.

Recommendation 2: Ensure consumer and carer participation and engagement.

Active consumer and carer engagement and participation is critical to the development, implementation and review of the proposed framework. It is important that this be affirmed by a ministerial determination that the proposed framework be led by consumers and carers, with the active participation and engagement of staff in the mental health sector. Processes must be established for this to occur. Services will also need to be strengthened to provide accessible and responsive internal and external advocacy for consumers and carers.

This determination will formally acknowledge the experience and value that consumers and carers bring to reform.

Prioritise the allocation of adequate financial and other resources to support the development, implementation and review of the proposed framework.

Recommendation 3: Ensure adequate resourcing and sustainability.

Adequate financial and material resources are needed to secure the implementation and ongoing functioning of the proposed framework. Funding will be required to provide:

- access to interpreters and bilingual or Indigenous mental health support workers to assist service users, family or carers wishing to lodge a complaint
- general training of staff in complaint monitoring and reporting
- dedicated and specifically trained complaints management staff across the service system and in the Department of Human Services
- a system for monitoring and enhancing the reporting of complaints.

Include as a Ministerial Advisory Committee priority in 2009 further collaborative work with the Office of the Chief Psychiatrist and the Office of the Health Services Commissioner with the aim of improving responsiveness to mental health complainants.

Recommendation 4: Ensure ongoing work in complaints management.

The complaints management project has highlighted the many avenues available to consumers and carers to make complaints. The Office of the Chief Psychiatrist and the Office of the Health Services Commissioner are the two key external avenues available to mental health complainants. Portfolio responsibility for these offices rests with different ministers and, given the significant vulnerability of people with a mental illness, it is critical that collaborative work be undertaken to enhance responsiveness to mental health complainants.

2. Introduction

The foundation of a complaints system lies in its ethical sensitivity to those who seek to use it. The requirement for robust systems of complaints management in mental health services can be seen as a response to other organisational imperatives, including quality assurance, risk mitigation and management, and consumer and carer engagement.

The right of patients to access statutory mechanisms of complaint and redress is enshrined in the United Nations *Principles for the protection of persons with mental illness and the improvement of mental health care*.² Most modern mental health laws contain many protections to safeguard the rights of patients receiving treatment and care for a mental illness. To ensure that these protections are fulfilled, these laws establish specialist bodies to support patients or others on their behalf to make complaints about their treatment and care. The bodies have powers to resolve complaints and promote service improvement. The World Health Organization maintains that it is crucial that involuntary patients have access to a specialist mental health complaints mechanism, which is independent from mental health service providers and government departments.³

2.1 The Victorian context

In Victoria, consumers receiving treatment and care in clinical mental health services are expected to access the same complaint mechanisms available to all health service consumers. Victorian public health services are required to establish complaint mechanisms as a condition of their funding.⁴ The process in the psychiatric disability rehabilitation and support (PDRS) services sector is less regulated, although both Victorian public mental health services and PDRS services are required to comply with the *National Standards for Mental Health Services*, which stipulate a requirement to establish complaints management processes. Consumers of PDRS services may lodge a complaint with the service provider or its auspicing authority and may escalate an unresolved complaint to the relevant regional office of the Department of Human Services.

Although not established for this purpose, the Office of the Chief Psychiatrist receives numerous complaints about mental health service delivery.⁵ The Chief Psychiatrist is responsible (under the Mental Health Act) for the welfare of people receiving treatment or care for a mental illness. The Office of the Chief Psychiatrist provides an enquiry and complaint line that offers advice and assistance to consumers, carers, members of the public and mental health service providers and clinicians on matters relating to treatment and care.

² Principles 21–22: United Nations *Principles for the protection of persons with mental illness and the improvement of mental health care*, Adopted by General Assembly resolution 46/119 of 17 December 1991.

³ World Health Organization, 2005, *WHO Resource Book on Mental Health, Human Rights and Legislation*, WHO, Geneva, p.71

⁴ *Health Services Act 1988* (Vic), s 26(4)(d)(ii). See also Victorian Department of Human Services, 2007, *Sentinel Event Program annual report 2006–07*, Melbourne, p.6.

⁵ In 2007 the Office of the Chief Psychiatrist received 394 complaints about mental health service delivery issues. Source: Department of Human Services, 2008, Chief Psychiatrist's complaints database, unpublished data.

Complaints are received by telephone and in writing.⁶ In responding to complaints and enquiries, the Chief Psychiatrist is assisted by departmental staff, including clinical advisers with mental health expertise.⁷

The Chief Psychiatrist has statutory powers to make enquiries regarding a person's treatment and care, and regularly liaises with public mental health services to resolve complaints for patients, carers and families.⁸ The Chief Psychiatrist also has statutory powers to conduct investigations where there are concerns that a patient's medical care and welfare is at risk or where there are concerns about standards of practice.⁹

Some complaints are received by other complaint-handling bodies established under separate legislation. In their role as advocates, community visitors resolve some patient complaints in person when they visit inpatient mental health services to perform routine inspections.¹⁰ Community visitors also receive telephone complaints via the Office of the Public Advocate's enquiry line.¹¹

The Office of the Health Services Commissioner (HSC) is an independent statutory authority established under the *Victorian Health Services (Conciliation and Review) Act 1987*. The HSC receives complaints about mental health services as part of its function to receive and resolve complaints about health services and health information privacy.¹² It generally receives complaints from patients and their nominated representatives but not from other carers or family members.¹³

Complaints are usually received by telephone, and must be confirmed in writing.¹⁴ Primarily the HSC receives general health and private sector complaints. The HSC aims to resolve most complaints through the exchange of letters with health services.¹⁵ It has powers of conciliation, investigation and inquiry but no powers to make treatment decisions or to recommend prosecution for breaches of the Act.¹⁶

6 Of the 394 complaints received by the Office of the Chief Psychiatrist in 2007, 276 were made by telephone and 118 were written. Source: Department of Human Services, 2008, Chief Psychiatrist's complaints database, unpublished data.

7 See Mental Health Act, ss. 105(2), 105(5), 106(1).

8 See Mental Health Act, s. 106.

9 See Mental Health Act, s. 106(4).

10 Community visitors are required to visit public mental health services at least once a month to enquire into the adequacy, appropriateness and standard of facilities. They have specific statutory functions to enquire into complaints made by patients: Mental Health Act, s. 109(g).

11 Further enquiries are managed by the Office of the Public Advocate. See: Office of the Public Advocate, 2007, *Office of the Public Advocate Annual Report 2007*, OPA, Melbourne, p.44.

12 The HSC receives complaints about health services pursuant to the *Health Records Act 2001* (Vic) and complaints about health information privacy under the *Health Services (Conciliation and Review) Act 1987* (Vic). In 2006–07 the HSC received 98 complaints relating to mental health services. Source: Office of the Health Services Commissioner, 2007, *Annual report 2007*, Office of the Health Services Commissioner, Melbourne p.30.

13 Generally the HSC does not receive complaints from other family members or carers unless it is of the opinion a patient is unable to complain or choose a representative to complain and that the person seeking to represent the patient has a sufficient interest in the subject matter of the complaint: *Health Services (Conciliation and Review) Act 1987*, s. 15.

14 *Health Services (Conciliation and Review) Act*, s. 17(2).

15 Office of the Health Services Commissioner, 2007, *Annual report 2007*, Melbourne p.15.

16 *Health Services (Conciliation and Review) Act*, ss. 9(1)(a)–(o), 10.

In most cases the HSC is not bound to produce a ruling,¹⁷ however, it can request that a health service take action to remedy a complaint and report on any action taken.¹⁸

A number of other statutory bodies also may receive complaints about matters related to treatment and care provided by mental health services. Complaints related to guardianship are received by the Office of the Public Advocate, complaints about health practitioners are received by professional registration boards, complaints about discrimination, sexual harassment or vilification are received by the Victorian Equal Opportunity and Human Rights Commission and complaints about action taken by government departments and statutory bodies are received by the Ombudsman.¹⁹ Involuntary patients have a right under the Mental Health Act to appeal to the Mental Health Review Board at any time if they wish to challenge their involuntary treatment.²⁰

Complaints management practices can vary between organisations and sometimes between different programs within the same organisation. Generally, the same formal elements are evident in both clinical and PDRS services: a complaint is made; a process is followed; an outcome determined, communicated and actioned. Based on information collected in the review, the following is a generic complaints management pathway:

- A formal (written) or informal (verbal) complaint is received by a member of staff. An advocate or consumer representative may be involved at this point.
- Staff attempt to resolve the complaint at the point of service.
- If successfully resolved, a verbal complaint may or may not be tracked and recorded.
- Formal complaints and locally unresolved verbal complaints will be written down (sometimes by staff or by a consumer/carer advocate).
- Complaints are directed either to management for a response or to a complaints liaison officer, who acknowledges the complaint to the complainant and forwards the complaint to the appropriate program manager for a response.
- Details of the complaint are logged on a data system for tracking.
- A meeting may be called to talk to the complainant and a consumer or carer advocate or an investigation may ensue.
- A letter to the complainant is prepared for sign-off by a complaints officer or manager, outlining actions taken, or to be taken, and any investigation findings.

¹⁷ Under the Health Records Act 2001 the HSC is bound to issue a ruling regarding any interference with health information privacy, but this obligation does not exist under the Health Services (Conciliation and Review) Act in relation to complaints about health services.

¹⁸ Health Services (Conciliation and Review) Act, s. 22.

¹⁹ Pursuant to the *Guardianship and Administration Act 1986* (Vic), *Health Professions Registration Act 2005* (Vic), *Equal Opportunity Act 1995* (Vic), and *Ombudsman Act 1983* (Vic) respectively.

²⁰ Mental Health Act, s. 29(1).

- Relevant data is reported to the organisation's internal quality-assurance mechanism or to a governing board of directors. Clinical services also provide data to the Office of the Health Services Commissioner.
- An unsatisfied complainant can ask for a review or take the matter to an external body for another response.
- A complainant may take action through several external bodies at the same time in response to a complaint. These may include the Office of the Health Services Commissioner, Office of the Chief Psychiatrist or Mental Health Review Board.

It is important to note that clinical mental health services in Victoria are provided on a geographical basis and consumers wishing to access these services are directed to service providers according to their residential address. This is designed to foster continuity of care but means that consumers cannot choose their service provider. Service providers are responsible for being respectful and attentive to the needs of consumers and must ensure that their service is responsive to feedback and complaints.

Complaints systems within Australia and internationally recognise that, ideally, most complaints will be resolved promptly at a local level. Patient advocates argue that complaints made by patients at a local level often are not dealt with in a transparent or rigorous manner.²¹ They also argue that local-level complaints information is not made publicly available to inform service-system improvement. There is no requirement that mental health services report or publish information on the number of complaints they receive, or the action they have taken in response to complaints.²²

2.2 Purpose of the project

Anecdotal evidence suggests considerable variability in local policies and procedures for dealing with consumer and carer complaints about mental health services. The purpose of the Mental Health Complaints Review Project was to review complaints processes to identify factors that will enhance existing complaints management processes. The current complaints system is complex because of the number of external bodies and pathways for complaints and appeals, which makes the system difficult for consumers and carers to navigate. This project compares best practice standards in complaints management and current practice, and incorporates information derived from interviews and focus groups with consumers and carers.

²¹ Victorian Mental Illness Awareness Council December 2007, *VMIAC Newsletter*, vol 11, no. 4, p.2.

²² *The Disability Act 2006* (Vic), s. 105 requires disability service providers to report annually to the Disability Services Commissioner specifying the number of complaints received and how the complaints were resolved.

2.3 Project scope

This project is timely in light of the consultations occurring this year with the review of the Mental Health Act. The review of the Act will consider and explore the Chief Psychiatrist's role and alternatives for complaints about treatment and care. Accordingly, this project will limit its scope to improvements in policy development and processes in complaints management. Ten adult mental health services participated in the review (five adult clinical mental health services and five psychiatric disability rehabilitation and support services (PDRSS)). Of these, six services were located in metropolitan Melbourne and four were based in rural and regional Victoria. The services were determined by the consumer and carer subcommittee based on:

- an optimal geographic spread of services and mix of programs provided
- at least three large PDRSS
- at least one clinical adult mental health service with a high escalation of complaints to the Chief Psychiatrist
- one clinical adult mental health service with a low escalation of such complaints
- one psychiatric disability rehabilitation support service with a prevention and care facility.

2.4 Constraints of the project

It is important to note the constraints of the project. It focused on information gained from a limited selection of mental health services about current practice in complaints management at a point in time. The snapshot that results is partly formed by input from mental health services management and staff, consumers and carers and selected stakeholder bodies, which either deal with complaints when they are escalated or advocate on behalf of consumers and carers.

Consumers and carers participating in this review were self-selecting. This inherently creates a bias; however, corroborative information from the audit supports some of these accounts of the complaints process.

2.5 Themes from the literature

This project has been informed by a review of best practice literature, as well as key reference points such as the *Better practice guidelines on complaints management for health care services, 2004* ('the guidelines') published by the Australian Council for Safety and Quality in Health Care and the *Good practice guide – Ombudsman Victoria's guide to complaint handling for Victorian public sector agencies*, April 2006.

The guidelines are intended to provide practical assistance to organisations to develop and improve their complaints management systems. The guidelines adopt a best practice approach rather than fixed benchmarks or standards and promote continuous quality improvement.

The guidelines have been informed by research derived from various sources including:

- *Annotated literature review 2003*, reviewing Australian and international research on good complaints management across a range of industries
- *Survey of examples of better practice complaints management by Australian health care services 2003*, which examined the complaints management systems of 53 health services
- a briefing paper reviewing standards on complaints management and quality improvement
- *Turning wrongs into rights*, an address by Professor Linda Mulchay of the University of London, delivered in 2003.

The guidelines note that poor follow-up and lack of proper acknowledgement of consumer concerns are common sources of dissatisfaction with complaints management. A collaborative approach, where services work with consumers and carers, is advocated as the best way to identify and resolve concerns.

Positive organisational culture or attitude is seen as fundamental to a successful complaints management system. The literature review highlights difficulties that health care professionals may have in accepting complaints, as they may be interpreted as criticisms of professional competence. For various reasons, consumers and carers find it hard to complain and require support to do so effectively.

Conceptual tools

The guidelines directly informed the development of the analytical tools for this project. The audit, focus group, individual interview and key stakeholder templates share a common key practice base that has been derived from a review of the literature. It is presented on the following pages.

1. Commitment to consumers and quality improvement

- Complaints are seen as integral to the organisational culture and senior management is apprised of complaints received.
- Complaints processes are regularly reviewed and improved.
- Staff view complaints and feedback from consumers as positive input to improving services as part of a continuous quality-improvement program.
- Complaint processes are adequately resourced, including staff training in complaints management, debriefing of staff involved in a complaint, and employing independent mediators in event of breakdown in relationships between a complainant and staff.

2. Accessible

- Well-publicised and clear information about how to lodge a complaint and the complaint investigation process is available for consumers in the format of brochures, handbooks and posters.
- Services encourage consumers to provide feedback about the service through an open-door policy, for example, via a suggestion box.
- Services facilitate receipt of complaints from people with special needs, for example, through interpreter services.

3. Responsive and timely

- Each complaint is formally acknowledged upon receipt by an established timeline.
- Consumers are informed of the progress of their complaint at each stage of the complaint resolution process.
- There are established timelines for complaint resolution. This may be based on complexity and other factors rather than a one-size-fits-all approach.

4. Accountable and transparent

- All complaints are recorded, tracked and documented.
- Staff members are given clear responsibility for dealing with complaints.
- Each service is to provide quarterly complaints data to the responsible authority, such as the Office of the Health Services Commissioner or the Department of Human Services.

5. Effective assessment and investigation of complaints

- A tiered approach to complaints handling is implemented ranging through informal, formal, serious and unresolved complaints.
- Complaints resolution is encouraged at the point of service by clinicians and staff. Escalation to investigation process is generally only required in complex or serious cases.
- Risk factors and assessment of the severity of risk associated with a complaint is considered.

6. Fairness and impartiality

- Each complaint is carefully considered by the service as a legitimate complaint without prejudice.
- Complaints are resolved appropriately and in an unbiased manner by taking into account relevant issues in order to provide just outcomes for all parties.

7. Privacy and open disclosure

- Confidentiality of the complaint and complainant's identity is protected throughout the complaint process.
- Access to complaint records is limited.
- An open disclosure policy requires relevant facts and decisions to be openly communicated and is understood by all staff.

8. Evaluation and improvement

- There is regular evaluation of all complaints to enable a review of individual cases, to identify trends and risks, and to report on how complaints have led to improvements.
- Consumers and staff evaluate the service's complaints management policy through surveys and focus groups, to encourage recommendation for improvements.

9. Complaints management policy and procedures

- Documented policy includes a written statement of values, which guides decision making.
- The procedures include steps with established timelines involved in handling a complaint and provide staff with a checklist for handling complaints, case studies and training aids.
- A list of remedies is identified as possible outcomes in dealing with a complaint, including apology, assistance/service, explanation, policy review and process review.

2.6 Methodology

The methodology for the review included the use of audits, consumer and carer focus groups, consumer and carer individual interviews and interviews of individuals and panels. Audits were conducted at 31 sites and covered a range of mental health programs.

The purpose of the audit was to ascertain the extent to which services had structures and processes in place for complaints management and the degree to which they complied with best practice. In the audit process, managers and complaints liaison officers were interviewed. This was followed by a verification process with staff, a visual inspection of premises and an examination of recently closed complaint files to assess the quality of responses to complaints.

Twenty local focus groups, 10 each of consumers and carers, were held across audited services. These focus groups were led by the consumer and carer representatives of the Victorian Mental Illness Awareness Council and the Victorian Mental Health Carers Network. A total of 128 people participated in these groups. The focus groups captured the experience of complainants, identified the themes of the complaints and considered suggestions for improving the complaints management system. The consumer and carer representatives also conducted 10 individual interviews, five each of consumers and carers. These interviews provided a narrative of the experience of the mental health complaints system. The interviews helped to identify systemic issues requiring attention and explored options for service improvement.

Finally, representatives from 14 organisations participated in key stakeholder interviews, including the Office of the Ombudsman, the Office of the Health Services Commissioner and other bodies that have formed some impression or understanding of complaints processes in mental health services, even if indirectly, in the course of exercising their functions. This group provided input on mental health complaints processes from an external perspective.

3. Service audit results

The 10 mental health services approached to participate in the project responded with openness and generosity. Many of the services have started to implement changes to their complaints management systems, while other services are midway through a change process for complaints. In some services there appeared to be a strong commitment to improve the experience of consumers and carers using the complaints system. All services requested feedback about their service performance against best practice standards and information about opportunities to improve their complaints processes.

The audits were undertaken to gain a snapshot of complaints policies and practices in mental health services. The results were compared with those of the audit tool derived from a literature review of best practice principles and standards for complaints management, any identified disparities providing scope for improvement.

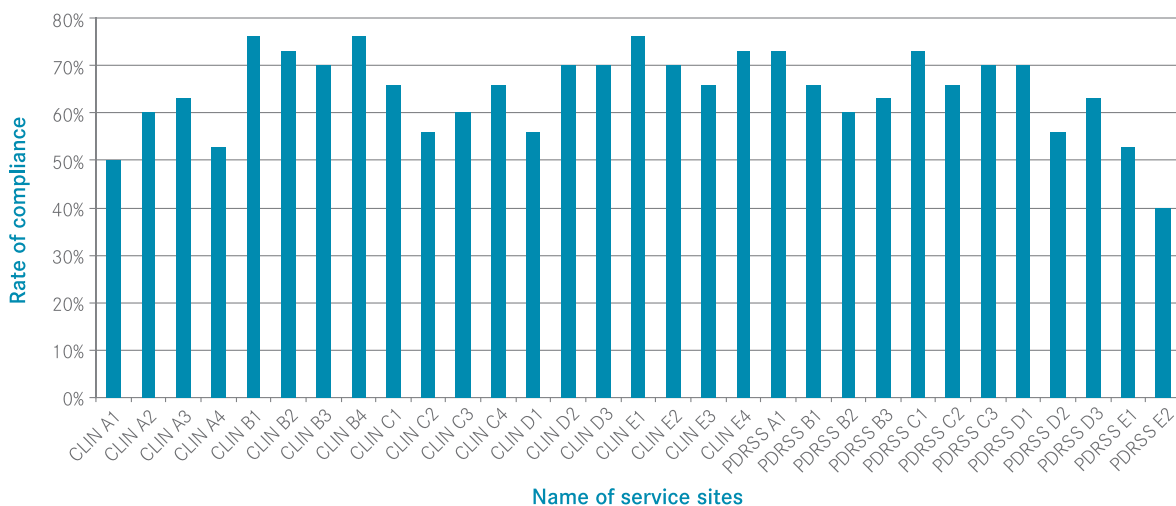
The audit tool comprised 30 questions with yes or no answers presented according to nine key principles including accessibility, accountability and transparency. Usually, at each mental health service, three sites were audited to capture a mix of programs offered; in all, 31 distinct programs were audited. The maximum score for an audited program (where 1 = yes and 0 = no) is 30, which would demonstrate 100 per cent compliance with best practice standards.

3.1 Results of audits

Service sites compliance with practice standards

Figure 1 provides information about the degree of compliance of each of the 31 service sites with audit practice standards. No service site was found to be 100 per cent compliant with best practice standards.

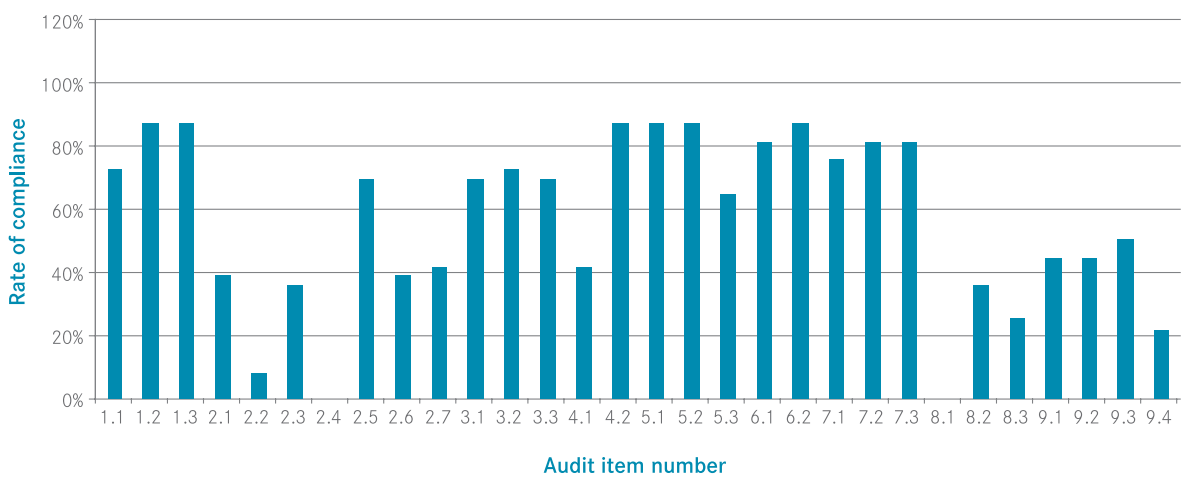
Figure 1: Rate of overall compliance by all service sites



Compliance with practice standards

Figure 2 shows the extent to which each of 30 audit practice standards are complied with across all audited service sites. Gaps in practice standards are noted for access and visibility of the complaints process and staff training.

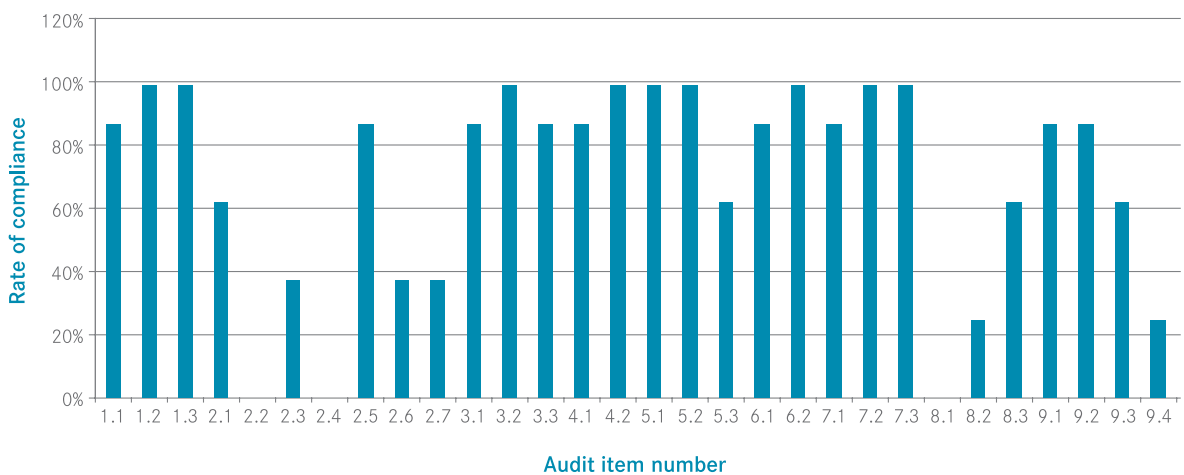
Figure 2: Rate of compliance against audit items, all service sites



Inpatient units' compliance with practice standards

Figure 3 gives rates of compliance for clinical inpatient units against the audit practice standards. Major gaps are identified in access and visibility and with complaints management training.

Figure 3: Rate of compliance against audit items by clinical inpatient units



3.2 Analysis of the data

Aggregate finding

- For all mental health service programs audited against all standards, there is an aggregate compliance with best practice of 65 per cent.

Programs

- The two highest score categories for compliance with best practice standards in a program are 23/30 or 76 per cent and 22/30 or 73 per cent and obtained in seven of 31 or 22.58 per cent of programs audited.
- The two lowest score categories for compliance with best practice standards in a program are 12/30 or 40 per cent and 15/30 or 50 per cent and obtained in two of 31 or 6.45 per cent of programs audited.

Standards

- The two highest score categories for compliance with a best practice standard across all programs are 31/31 or 100 per cent and 29/31 or 93 per cent and obtained in nine of 30 or 30 per cent of practice standards.
- The two lowest score categories for compliance with a best practice standard across all programs are 0/31 or 0 per cent and 3/31 or 9 per cent and obtained in three of 30 or 10 per cent of practice standards.
- Audits show poor compliance is mainly distributed across practice standards relating to the visibility and accessibility of the complaints process and the training of staff. This was evident in both clinical and PDRS services programs.
- Clinical services score higher in having key performance indicators for complaints when compared with PDRS services.

3.3 Observations

Accessibility

The complaints process was well publicised in 45 per cent of programs. There was limited material on complaints management in residential and, in particular, acute inpatient services. Complaints materials were generally more visible in community-based settings. No mental health service had a complaints box and only 41 per cent had suggestion boxes.

In services where complaints materials are limited or absent, alternative materials on rights, advocacy and legal assistance are usually displayed. There was minimal to no complaints materials in languages other than English, although advocacy and mediation materials were usually available in other languages. A clinical service that scored high for compliance had no complaints box or suggestion box, yet complaints were identified and appeared to be appropriately managed.

Information on how to lodge a complaint was available in all mental health services where complaints material was displayed, yet only 45 per cent of these materials further explained the investigation process. Timelines for complaint resolution were sometimes apparent in policy documents for staff but, with two notable exceptions, not in the information provided to consumers and carers. In the complaints materials examined, only 48 per cent included further information on mediation and advocacy.

Training and education

All services reported providing staff training in complaints management on induction. Policy materials were typically available in hard copy or via organisational intranets and staff generally are instructed to go to their managers and/or complaints liaison officers for assistance when dealing with complaints. While some services recently had reviewed or were reviewing their complaints procedures, there is no routine ongoing training in complaints management offered to staff. While all staff interviewed could outline a basic knowledge required in handling complaints, such as seeking local resolution first then assisting the complainant to access materials, there were varying degrees of knowledge about the complaints management processes.

About 41 per cent of managers interviewed reported having had some earlier complaints/conflict management training as part of their professional background. There was little recognition of the policy of open disclosure in mental health services (29 per cent) but when recognised, this tended to be by staff with a clinical background.

Evaluation and improvement

Most mental health services (93 per cent) provided complaints data to the relevant authority (typically an internal quality-assurance body). Clinical mental health services also provide data to the office of the Health Services Commissioner through the Health Services Commissioner's Information Program (HCIP). Only 51 per cent of mental health services had complaints reported as one of their key performance indicators and these were predominantly from clinical settings.

The review revealed considerable variation in the practice of complaints management. In some mental health services written complaints are preferred. In others verbal complaints are encouraged as well. Informal or verbal complaints are addressed but not all services attempt to capture the resolution of informal complaints, particularly in residential and inpatient services. The absence of monitoring of informal complaints emerges as an outstanding issue.

In some health services there is one system for handling complaints; in others, the mental health service has its own parallel structure and process. In some services, the prescribed policy time to acknowledge a complaint letter varied from 48 hours to five days, while responses were set at 28 or 30 days. The industry standard is 28 days and is in keeping with the Health Services Commission protocol, where a complaint is confirmed and then sent to the health service provider requesting a response within 28 days. Staff indicated that the response to informal complaints was prompt when compared with formal complaints because they try to resolve complaints at the point of service before escalating up through management.

Based on a sample of complaints files, typical subjects of complaint included: poor discharge planning; lack of access by consumers or patients to psychiatrists and workers; not being able to access a program; wanting a change of case worker; lack of respect from staff to patients; dissatisfaction with treatment plans; and associated clinical issues such as medication side effects. A copy of the audit tool is found at Appendix 1.

3.4 Findings from service audits

1. Less than half of audited services have adequately publicised complaints processes.
2. No audited service had a public box specifically reserved for the receipt of complaints.
3. Inpatient and residential settings constituted 47 per cent of audited programs with an inadequate display of complaints materials.
4. No mental health service had ongoing regular complaints training for staff over and above standard induction procedures and on-the-job learning.
5. Key performance indicators for complaints management exist in 51 per cent of services audited and these were predominantly in clinical services.
6. Informal or verbal complaints are not always captured and tracked.

4. Consumer focus groups

Ten local focus groups with consumers were conducted at selected audited sites and facilitated by project workers from the Victorian Mental Illness Awareness Council.

4.1 Purpose of focus groups

The purpose of the focus groups was to gain some understanding of consumers' experience of the complaints process. A total of 67 consumers attended the 10 focus groups. Of those attending, 13 per cent of participants had previously made formal complaints and they were represented in half of the focus groups. Approximately 90 per cent of consumers attending focus groups had previously made informal complaints. A copy of focus group questions is found in Appendix 2.

4.2 Focus group themes

Table 1 identifies recurrent themes emerging under key focus areas. The major observations list the themes most commonly expressed by consumers and the minor observations list themes less commonly expressed.

Table 1: Recurrent consumer focus group themes

Key focus areas	Major observations	Minor observations
Accessibility	<p>Not well promoted</p> <p>No material on mediation and advocacy</p> <p>Suggestion boxes not obviously labelled or difficult to access</p> <p>Complaints material unclear</p>	<p>Some material on complaints available but the process unclear or material difficult</p> <p>Very good advertising of process with information of quality</p>
Responsiveness	<p>No timelines</p> <p>Long response times</p> <p>No responses or responses not addressing issues</p> <p>No acknowledgement of complaints</p> <p>Consumer consultants important to navigate system</p>	<p>Variable response times from seven days to nine months</p>
Investigative capacity	<p>No confidence in staff ability to investigate a complaint properly, especially if staff are the subject of complaint</p> <p>No updates on complaints during investigation</p> <p>Process is 'faceless'</p>	<p>Service should be able to conduct independent self-investigations</p> <p>Expressions of confidence that a service can investigate itself properly</p>
Impartiality	<p>No confidence that staff can be impartial</p> <p>Fear of reprisals</p> <p>Staff discourage complaints</p> <p>Complainants need an independent person</p>	<p>Staff responsive and supportive</p> <p>Some confidence that staff can be impartial</p>

4.3 Discussion

Participants expressed differing views about the visibility of the complaints system. One participant stated that the complaints system at his service was never promoted, and that 'I only heard about it at the [Consumer Advisory Group]'. Other participants noted that there were no forms to fill in or that suggestions boxes (which double as complaint boxes) were not labelled or obvious. A number of participants at one service indicated that 'staff removed complaints brochures from the rack' and quoted staff as saying 'we are getting too many complaints'. A participant related that when discharged 'they gave me back all the complaints I had made over several months ... nothing was done about them'. Another participant stated 'a lot of people aren't aware of what happens to a complaint'.

Participants at other services noted that there were materials advertising the complaints process but the quality of information was lacking. Response times for resolution were variable. In some cases, participants reported a quick turnaround time; in other instances, participants reported that between three and nine months had elapsed before they received a response. In the meantime, 'you just don't know if there has been an investigation'.

Most consumer focus groups reported a lack of confidence in mental health services to conduct investigations in a fair manner although some qualified this by saying they had confidence in the impartiality of services as long as the complaint was not about a staff member. Participants felt either that complaints against staff were too difficult to investigate impartially (because staff stick together) or that some form of retribution would occur to complainants. This latter sentiment appears a significant reason that many focus group participants wanted an 'independent body' or a 'mental health advocate' to manage their complaints. Other participants reported that complaints were downplayed by some staff who regarded the complaints as expressions or symptoms of mental illness.

One focus group reported a high level of satisfaction with its mental health (PDRS) service. This appeared to be due to good relations with staff and an ethos that encourages direct consumer involvement in policy development. A consumer reference group ensured that 'we had input so that [the complaint policy] is in plain English and is understandable'.

Three focus groups expressed strong degrees of satisfaction with elements of the complaints process in their local mental health services, in particular identifying the visibility of the process, good response times and confident relations with supportive staff.

Focus group participants expressed the hope that the project would result in service improvement. Many groups also expressed satisfaction with other aspects of their mental health service.

4.4 Summary of consumer focus group data and discussion

- Focus groups present an impression of variable practices and standards of complaints management.
- There is a general lack of visibility of the complaints system and impressions of non-responsiveness and a fear of making complaints.
- Good complaints practice is associated with consumers being directly involved in formulating the complaints management process.

Ten locally based focus groups with carers were conducted at selected audited sites and facilitated by project workers from the Victorian Mental Health Carers Network.

5. Carer focus group themes

5.1 Purpose of focus groups

The purpose of the carer focus groups was to gain some understanding of carers' experience of the complaints process.

A total of 61 carers attended 10 focus groups. Approximately 13 per cent of attendees had previously made formal complaints and they were represented in four of the focus groups. Most groups comprised people with some experience of informal complaints and one group of carers had not made any complaints.

5.2 Thematic summary of carer focus groups

Table 2 identifies the recurrent themes emerging from the carer focus groups under key focus areas. The major observations are those appearing more frequently in the data followed by less frequent or minor observations.

Table 2: Recurrent carer focus group themes

Key focus area	Major observations	Minor observations
Accessibility	No promotion or information on complaints available at service No information on what happens once a complaint is lodged and no information is available about the process	Staff assist with making a complaint Carers' packages available with complaints information
Responsiveness	Response timelines not known Responses take from seven days to five weeks Carers often ignored or dismissed when raising concerns Carers not informed about timelines for either acknowledgements nor response to complaints	Update phone calls by staff on complaint progress had been provided to carer Staff do respond promptly to informal requests
Investigative capacity	No information on the investigative process Not confident of service's capacity to properly investigate a complaint	Capacity of service to properly investigate complaints linked to resources
Impartiality	Fearful of making a complaint Complaints process is not independent of service	Impartial yes, but not if staff are the subject of complaint

5.3 Discussion

The thematic summary shows, not unexpectedly, that carers' experience of the complaints system mirrors that of consumers. There are, however, some differences.

Most focus group participants consistently report little if any awareness of complaints processes being advertised and some carers were not aware that services had a formal complaints process in place.

In one service, there were inconsistencies around complaints management promotion. For example, some carers reported being given pamphlets or a carer's induction pack at their initial involvement while others report only being verbally briefed about the complaints process.

Where suggestion boxes were present, they were not prominent and typically did not have information about the process and timelines for resolution.

High regard was held for carer advocates who were often considered the sole or best source of information and help with complaints processes.

There was considerable variability in the time it took for complaints to be acknowledged and resolved. Sometimes complainants were kept informed, but more often it appeared they were not; some participants were contacted quickly, others waited nearly six months for feedback from the service, and sometimes no feedback was forthcoming.

Carers also reported being worried about making complaints because of possible repercussions for their loved ones in care. The virtual absence of clear pathways to complain also affected the perception of mental health services' ability to be accountable for complaints management because the process was not transparent. Concerns were raised for new carers who would have to navigate the complaints system.

In contrast to consumer focus groups, the carer focus groups were evenly split on whether services could adequately and impartially resolve formal complaints.

Carers reported that some staff were dismissive of their concerns and requests for feedback and that at times they felt like 'serial whingers.' This sentiment is compounded in part by high staff turnover and the need to repeat concerns to new staff. The importance of a good staff response to initial complaint queries was identified as crucial to the quality of the complaints experience. Some carers reported being contacted by staff by phone and criticised for making a complaint.

Instead of using formal complaint mechanisms, carers report making use of established relationships with ongoing staff to follow up and resolve their complaints informally. At one of the services, carers reported not having much confidence at 'head office' level but found that individual workers in specific programs were marvellous advocates 'who dealt with things on the spot, so they don't become problems'. While the efforts of individuals are commendable, the effectiveness of a complaints system must rest on broader, more objective and consistent foundations.

Two key difficulties were identified by carers: that, relative to consumers, they feel they receive less information about their rights and access to complaint mechanisms; 'the service does not support carers to engage advocates'; and carers express the belief that they occupy a difficult position in the mental health services system. Many consumers in clinical settings may have strained or ambivalent relations with key family members or carers. 'There can be a conflict of interest in the service – families can be painted in a very negative light; however, the client's story does take precedence, creating a very complex situation.' This situation can inhibit staff feedback to carers (via citing of privacy and confidentiality issues) and there is always the fear that complaining may adversely affect their relationship with staff.

From the carers' perspective, unsatisfactory relations with services can be largely put down to poor communication, with staff often not being receptive to carer concerns, which results in strained communications.

5.4 Summary of carer focus group data and discussion

- Complaints management systems are not well known by carers.
- There is a consistent lack of access to complaints pathways for carers.
- There are varying standards of responsiveness to complaints.
- There is a lack of transparency of the complaints system.
- Good communication with staff is a crucial determinate of the quality of the experience of a complaints process.

5.5 Findings from consumer and carer focus groups

7. Complaints materials are not very visible and there are no obvious and clear processes for complaints investigation and resolution.
8. The complaints materials that are available generally did not explain the whole process for complaints management or matching timelines.
9. Consumers and carers believe that complaining will put them at risk of retribution by some staff.
10. There is a general lack of:
 - confidence that mental health services will be impartial when investigating complaints about staff
 - feedback to complainants regarding the status of their complaint while it is under consideration.
11. Empathy and good communication by staff directly affected the quality of the complaints experience and had the potential to render a complaint unnecessary.
12. Direct consumer and carer input into complaints policy development and implementation is associated with good practice in complaints management.

6. Individual consumer interviews

6.1 Purpose of consumer individual interviews

Five individual interviews with consumers who have had direct experience of mental health services in Victoria and of their associated complaints processes were facilitated by consumer representatives from the Victorian Mental Illness Awareness Council.

The purpose of the individual consumer interviews was twofold: to listen to their experience of the complaints process and to identify systemic aspects of complaints processes that can be improved. All interviewees were consumers of clinical mental health services, all have made formal (written) complaints to their respective services and all have had significant exposure to the complaints process.

Individual interviews were structured in the same way as the focus groups: around a key set of questions and principles. Individual interview questions can be found at Appendix 3.

6.2 Thematic summary of consumer interviews

Table 3 identifies recurrent themes emerging from the interviews. The major observations are those occurring more frequently in the data followed by the minor observations that appear less frequently.

Table 3: Recurrent consumer interview themes

Key focus areas	Major observations	Minor observations
Accessibility	<ul style="list-style-type: none"> Minimal access Information only on intranet No help from staff to access process No clear information on process No information available 	<ul style="list-style-type: none"> Pamphlets on complaints are too small to fill in Consumer consultants the only source of assistance
Responsiveness	<ul style="list-style-type: none"> No assistance from staff No follow-up on complaint 'You are not listened to' Very long delays and service non-responsive to queries No acknowledgement of or follow-up on complaints 	<ul style="list-style-type: none"> Initially, service was responsive, then a 'brick wall went up' Response letter from services defensive and denied any problems existed
Investigative capacity	<ul style="list-style-type: none"> No confidence in services investigating themselves Service denying problems exist No feedback on complaints 	
Impartiality	<ul style="list-style-type: none"> Lack of impartiality Denial by service of problems Fear of reprisals for complaining Process unclear, no transparency and therefore questionable impartiality No confidence in internal mechanisms for complaint investigation; services need to be independently accountable 	<ul style="list-style-type: none"> Complaints seen as a symptom of illness and so delegitimised

6.3 Discussion

All five interviewees experienced trying to engage mental health complaints services in inpatient clinical settings. All interviewees identified a number of factors that frustrated their attempts to use the complaints system and, more importantly, they conveyed the *experience* of negotiating a complex and at times isolating complaints system.

For the purposes of discussion, the complainants' journeys will be used to examine their experiences of making a complaint.

Making a complaint

Complainant A knew there was a complaints process and was able to access the form on the internet, though it was reported that the process was not visible on the ward and no staff assisted. The complaint was about being discharged from a unit without discharge planning or contact with the local GP to make discharge plans.

Complainant B made a complaint to a manager about a staff member's behaviour, which she perceived as 'stalking'. The complainant also raised the subject of adverse medication side effects ('feeling ill').

The initial service responses

A written response was provided to complainant A who indicated that it was a 'form letter' because it stated 'I am satisfied that you received the appropriate care and treatment whilst an inpatient in which ever ward of this hospital'. The letter did not address the concerns and hence another attempt was made to engage the service in resolution.

Complainant B reported that there was an initial response via a meeting with the unit manager, which seemed promising, but 'there were words of appeasement followed by nothing – a brick wall went up'.

Further engagement of the complaints process

Complainant A attempted to follow up issues via a consumer satisfaction survey, but despite frequent attempts by phone to obtain a copy from the manager, was not able to access it. The complainant reports that no offer of mediation was made or discussed.

Complainant B was refused further contact by the unit manager, and the perceived 'stalking' situation was resolved only when the complainant's partner spoke to the staff member involved. The staff member stated that he was unaware that his behaviour was causing distress.

Outcomes for complainants

Complainant A believes that the 'investigation' was a formality, 'a tick the box', and reported that they were not informed of their right to complain and that no one from the service spoke to them about their complaint. A follow-up letter was sent by the complainant to the service and a response remains outstanding.

Complainant B had written complaints without any apparent action being undertaken. The only feedback for the complainant was to 'talk to your nurse'. The complainant doubted that any investigation was made about the complaint and has not received any feedback.

In both cases, complainants report feeling 'fobbed off' or not listened to and respected; both worry about consumers who cannot be bothered making complaints because of the stress involved and both express the belief that complaints could be averted with improved communication and empathy.

One person's experience of the complaints process

This account from an interviewee relates to an experience of seclusion and subsequent attempts to access complaint mechanisms within the service at a local level.

The complainant was an inpatient who spent considerable time in seclusion. The complaint was about a lack of dignity in treatment and care while in seclusion. Both the complainant and their partner made several verbal and written complaints to the service. It took 11 months to gain the requested interview with the chief executive officer of the service. Initial written responses to the complaints indicated that an investigation had been undertaken and no grounds for complaint had been identified.

The complainant reports no assistance from staff in making the complaint, denials from the service that there was anything to complain about, not being listened to and that her involuntary status negated the validity of her complaint. The complainant reports that she was not told of her right to complain. The complainant credits an advocate she independently accessed, and her partner, with getting her through a daunting complaints process.

The matter was referred to the Office of the Chief Psychiatrist who substantiated the complaint. However, having no authority over conciliation or compensation, the Chief Psychiatrist referred the matter to the Office of the Health Services Commissioner.

There are a number of issues to note in this account: in addition to the service invalidating the complaint, the complainant reports not being offered any assistance with accessing avenues for complaint. The complainant was forced to seek external and independent advocacy for redress. The five complainant interviews convey an impression of a complaints system that varies from indifferent to punitive and one that is not responsive or accountable.

6.4 Summary of individual consumer interview data and discussion

- A culture exists where complaints are not regarded as valued feedback.
- There is minimal visibility of complaints processes with an associated lack of transparency and accountability.
- A punitive or indifferent attitude is displayed by some staff towards some consumers making complaints.
- There is apparent inadequate investigatory capacity and impartiality in some services.
- Some staff are not interested in dealing with complaints.
- The experience of negotiating a complaints process is emotionally confronting for consumers.

7. Individual carer interviews

Five individual interviews of carers who have had experience of mental health services in Victoria were facilitated by project workers from the Victorian Mental Health Carers Network.

7.1 Purpose of individual interviews of consumers

The purpose of the individual carer interviews was two-fold: to hear their experience of the complaints process and to identify systemic issues with complaints processes. Four of the five interviews involve carers of relatives in clinical services and one involves a relative in a PDRS service.

7.2 Thematic summary of individual carer interviews

Table 4 identifies the themes from the interviews; the major observations are those appearing more frequently in the data while minor observations are those occurring less frequently.

Table 4: Recurrent carer themes from individual interviews

Theme	Major observations	Minor observations
Accessibility	Need change of attitude by services to complaints Staff are defensive No information given on complaints or the process	Suggestion box observed but no accompanying material on what happens to complaints/suggestions
Responsiveness	Complaints process needs to be backed up with adequate training and resources Service not supportive during process Delayed response time to complaints	Good positive response to immediate concerns Good response from senior management but not from junior staff
Investigative capacity	Need to go to senior levels to get satisfaction	Whole complaints process needs proper resources
Impartiality	System not fair or impartial	Investigation adequate

7.3 Discussion

There is variability in service responses to complaints and it can require escalation to senior management in order to hasten a response. Often, carers are not informed of their right to complain until they wish to make a complaint. Some felt that it was likely that complaints resulted from a simple failure of services to communicate earlier with the carer.

On a positive note, it was noted that dealing with senior management led to a quick responses to concerns. Some carers noted that in some services there was a gradual change in attitudes towards complaints, which appeared to be treated more seriously than previously. Good communication was identified as a key issue. Carers felt that if communication was good in the first instance, complaints would be unnecessary. Carers frequently expressed a wish to be seen as partners with services.

7.4 Summary of individual carer interview data and discussion

- In general, these examples show that health services' complaints systems are difficult to engage because they are not transparent.
- There is a perceived lack of accountability to service users.
- The complaints management system emerges as being too complex to navigate with any certainty.
- The importance of good and open communication between staff and carers is a repeated theme in the data.

7.5 Findings from consumer and carer individual interviews

1. Services do not consistently abide by their own complaints policies for visibility, timeliness and adequacy of responses.
2. Consumers and carers feel significantly unsupported by services when making complaints.
3. There is a degree of active and passive discouragement of complaints demonstrated by some staff disregarding the complaint or complainant.

8. Key stakeholder interviews

Interviews were undertaken with representatives of 14 key stakeholder organisations. These interviews were undertaken jointly by the departmental project officer and representatives from the Victorian Mental Illness Awareness Council (VMIAC) or the Victorian Mental Health Carers Network.

8.1 Purpose of key stakeholder interviews

Key stakeholders are external to and independent of mental health services. Some of the key stakeholders have statutory roles regarding appeals and complaints. In the course of exercising their functions, key stakeholder organisations are typically exposed (in some instances indirectly) to aspects of complaints processes in mental health services.

Key stakeholders included representatives from a legal service centre, statutory bodies with responsibilities for examining complaints, as well as peak advocacy bodies for carers and consumers. These key stakeholder interviews provided an external perspective. A full list of key stakeholder organisations is found at Appendix 5.

8.2 Thematic summary of key stakeholder interviews

Table 5 identifies themes emerging under the key focus areas.

Table 5: Key stakeholder observations

Key focus areas	General observations
Accessibility	<p>Ad hoc assistance by staff to consumers trying to write complaints</p> <p>Mental health complaints system is complex to access and negotiate</p> <p>Problems of complaints fatigue: people give up complaining, especially if unwell</p> <p>Culture where involuntary patients are not asked for consent about aspects of their treatment</p> <p>Advocates seen as a threat and get short shrift</p> <p>Practice varies across services, with transparency and clear pathways to complaints mechanisms lacking across the service system</p>
Responsiveness	<p>There is a need for a more integrated pathway to the resolution of mental health complaints across the mental health sector, especially when complaints involve multiple agencies</p>
Investigative capacity	<p>Inadequate resources allocated for internal investigation of complaints</p> <p>Need for robust and independent complaints resolution process within services</p>
Impartiality	<p>Some services are very good at dealing with complaints, others are less so</p> <p>Effective resolution appears at times to boil down to the goodwill of individuals rather than the culture of an organisation</p> <p>Fear of making a complaint because of possible reprisals</p> <p>Use of mental illness labels to delegitimise consumer complaints in clinical settings</p>

Complaints noted included:

- catchment issues affecting continuity of care, as people moved across service boundaries
- use of involuntary status and seclusion as threats to regulate patient behaviour
- clinical issues around diagnosis and treatment plans
- allegations of physical and sexual assaults on wards
- inadequate discharge planning
- legal issues around involuntary status and electroconvulsive therapy practice
- complaints from members of the public who have no idea of where to go to get an issue addressed by mental health services
- faeces left in a seclusion room and spittle in drinking water
- invalid categorisation of a consumer from voluntary to involuntary status
- consumers in seclusion being left unclothed or forced to wear clothes that compromised their modesty
- seeing the matter of a complaint as an expression of psychopathology and thus delegitimising the seriousness of complaints and the complainant
- lack of access to workers and services
- restraint and seclusion practices vary at different services
- mental health facilities are often boring to be in, rather than therapeutic environments
- often each new admission is treated as though the patient had no history.

7.5 Findings from key stakeholder interviews

4. Complainants would be assisted by a more unified and integrated mechanism for handling complaints, particularly between services, appeal and external bodies.
5. Training has emerged as a key factor in cultural change around complaints management. There is a need for basic training of staff around complaints management.
6. The dual system where complaints in a mental health service are managed separately to those of other health complaints raises issues of governance.
7. The role of senior executives and boards of directors has been consistently identified as crucial to improving cultural and practice change in complaints management.

9. Systemic issues

Project data to date raises fundamental systemic issues, including the concern of some consumers and carers that they would suffer retribution for making a complaint. These issues are set out under the key focus areas below.

9.1 Accessibility

There is limited access to and visibility of the complaints process for consumers and carers. Engaging the process appears too dependent on the staff response to the initial complaint (person dependent) rather than engagement occurring due to culture, systems or processes.

9.2 Responsiveness

There is considerable variability in timeliness of responses to complaints. This ranges from short response times to no response at all. Service responses also are lacking where complainants have no assistance with making complaints and no awareness of the process by which complaints may be addressed.

9.3 Accountability

Accountability is linked to a number of factors including having a clear and transparent process for complaints management and ensuring there is appropriate governance of structure and process. There is very limited information on informal complaints except an observation that they are readily managed. The general lack of tracking for informal complaints means there is no accurate measure of their numbers and a reduced capacity to be accountable for them. This limits a systemic approach to service quality improvement.

9.4 Effective investigative capacity

The interviews and focus groups were consistent about the need for an independent investigation of complaints because of the potential conflict of interest when organisations investigate themselves. However, in relation to governance, organisations are obliged to undertake their own investigations to improve the quality of services and protect against risk.

Complaints liaison officers and service managers usually are not trained in the conduct of investigations. Participants identified resources and training as critical to improving the quality of internal investigations, particularly where members of staff are the subject of complaint.

9.5 Impartiality

There were differing views about the capacity of services to be impartial when handling complaints. Most interviewees reported that they felt services were not impartial when complaints were made about staff but could be impartial when complaints were about services or programs.

9.6 Discussion

The following discussion of key focus areas has been informed by the outcomes of key stakeholder interviews and presented under potential remedial categories.

Staff training

A consistent indicator of the quality of the consumer and carer experience of the complaints system is how staff approach complainants in the first instance. Better communication between staff and consumers and carers would often render a complaint unnecessary. Consumers and carers indicate that sympathetic help from staff in accessing the complaints process would go some way towards increasing their confidence in the system. The data suggests that staff require ongoing training in complaints management to improve their responsiveness to complaints.

It also suggests that managers who carry out investigations within a service require better training. Complaints liaison officers require appropriate status and resources to effectively resolve complaints.

Information gathered for this project also noted a lack of access to a transparent complaints process, which has direct bearing on consumer confidence in the system and for service accountability. It suggests a need for heightened visibility and better access to a better understood complaints system.

Carer and consumer advocates play a key role in facilitating and supporting people through the complaints process. Information from interviews and focus groups suggests that consumer and carer consultants should be more available and better used in services and should have input into the development and evaluation of complaint policies.

Institutional culture and leadership

Some consumers and carers report that some staff are not interested in complaints, either because they are too busy or don't see handling complaints as part of their role. Other accounts suggest consumer and carer advocates are not valued by service management and may be seen by staff as too aligned with clients.

Organisational culture was a prominent theme in the focus groups and interviews. Mental health services could improve organisational culture by regarding complaints as a valuable source of information and an opportunity for service improvement. A number of stakeholders affirmed the role of boards in fostering cultural change in complaints management.

The location of a complaints liaison person within an organisational structure was critical. Some stakeholders suggested it was important that the complaints liaison officer had ready access to directors, the chief executive officer and/or boards of directors.

Project data reflects the need for strong sector leadership for complaints management and the need for a central repository for complaints data collection and outcomes tracking. A central body also could produce and monitor service standards.

Quality assurance and complaints processes

Interview feedback indicates that many consumers and carers are not aware of what happens to complaints or even whether an investigation is conducted. Within one service, some consumers and carers reported that they had no trouble accessing information about the complaints system (for example, pamphlets) but others reported difficulties. In some services, help was available to draft a complaint while in others staff appeared unwilling to assist. This highlights variability in the quality and consistency of practice and suggests that a positive experience for consumers and carers may be more determined by the goodwill of individuals rather than good organisational policy and culture.

Some stakeholders linked difficulties in dealing with complaints from mental health services to the fact that in some clinical services there is a dual system where the governance of mental health complaints sits de-facto within the mental health service itself and is not clearly linked to the broader structures that oversee general health service complaints.

It was argued that one integrated system was preferable to a dual system for complaints management. In services with a split system, data and quality reporting are dependent on either the structural link between mental health and central complaints or good relations between key staff. It was suggested that mental health complaints should be treated no differently to any other health service complaint.

Key stakeholders identified the need for a much more integrated system of complaints management between different types of mental health services to ensure consistent access to complaints systems. Data from stakeholder interviews identified ‘complaint fatigue’ as not uncommon for carers and consumers seeking redress in a complex, poorly understood system. One suggestion was for an oversighting function to coordinate relations between different complaints bodies and provide consumers and carers with one point of access and exit. In this way consumers and carers would not have to do all the work to progress a complaint, which can be physically, mentally and time-exhausting.

An effective complaints management process at the local level requires not only appropriate policies and procedures but a culture of openness, quality improvement and effective support for carers and consumers. It should go beyond the resolution of individual complaints to provide the service with an insight into consumer perspectives/experience of care to assist in improving the quality of service. Some stakeholders noted a need for greater consistency of complaints standards and practices for the mental health sector. Others noted that standards from key accrediting bodies for clinical services and psychiatric rehabilitation and support services could form the basis of a more integrated complaints system.

Consumer and carer participation

In one PDRS service, strong positive feedback from consumers indicated good levels of satisfaction with complaints resolution processes because consumers were directly involved in the development and implementation of the complaints policy. Feedback regarding this PDRS service also identified supportive staff as a factor in a successful complaints management system.

Human rights

It is important for complaints to be considered in the context of human rights. This is particularly relevant when access to mental health services is determined by community catchments, diminishing the right of consumers to choose their preferred treatment service. The right to mechanisms of complaint and redress is a fundamental aspect of most mental health service systems and is enshrined internationally in the *Principles for protection of persons with mental illness and the improvement of mental health care*, adopted by the United Nations in 1991 and nationally in the *Mental health statement of rights and responsibilities (1991)* and the *National standards for mental health services (1996)*. The Victorian Human Rights and Responsibilities Act 2006 will reinforce legal mechanisms and policies that protect or enhance the rights of consumers, including access to complaints mechanisms.

The Mental Health Act, s. 4 (2)(a) and (b) obliges services to implement treatment in the least restrictive environment in the *least possible intrusive* manner consistent with the effective provision of care and treatment. The Charter of Human Rights and Responsibilities Act also sets out conditions under which rights may be limited and the factors that must be taken into account in any lawful limitation of a right, thus s. 7 (2)(a–e) specifies, among other things, the purpose and nature of the limitation and a least restrictive criterion.

Complaints mechanisms in public sector services will have to be compliant with the Charter of Human Rights and Responsibilities Act. This Act may come under the aegis of the anti-discrimination list at VCAT and thus become another ground of appeal regarding complaints.

10. Findings and recommendations

The data and information presented for this project has generated the following findings. They reflect systemic factors that render complaints management processes less than optimal.

1. Less than half of audited programs had adequately publicised complaints processes.
2. No audited service had a public box specifically reserved for receipt of complaints.
3. Inpatient and residential settings constituted 47 per cent of audited programs with an inadequate display of complaints materials.
4. No mental health service had ongoing regular complaints training for staff over and above standard induction procedures and on-the-job learning.
5. Key performance indicators for complaints management exist in 51 per cent of services audited and were predominantly in clinical services.
6. Informal or verbal complaints are not always captured and tracked.
7. Complaints materials are not very visible and there are no obvious and clear processes for complaints investigation and resolution.
8. The complaints materials that are available generally did not explain the whole process for complaints management or matching timelines.
9. Consumers and carers believe that complaining will put them at risk of retribution by some staff.
10. There is a general lack of:
 - confidence that mental health services will be impartial when investigating complaints about staff
 - feedback to complainants regarding the status of their complaint while it is under consideration.
11. Empathy and good communication by staff are factors that directly affect the quality of the complaints experience. They also have the potential to render a complaint unnecessary.
12. Direct consumer and carer input into complaints policy development and implementation is associated with good practice in complaints management.
13. Services do not consistently abide by their own complaints policies for visibility, timeliness and adequacy of responses.
14. Consumers and carers feel significantly unsupported by services when making complaints.
15. Consumers and carers believe that some staff disregard the complaint or complainant by being discouraging and dismissive.
16. A more unified and integrated mechanism for handling complaints, particularly between services and various appeal bodies, would assist complainants.
17. Training is a key factor in cultural change regarding complaints management. There is a need for basic training for staff around complaints management.
18. The dual system where complaints in a mental health service are managed separately to those of other health complaints raises issues of governance.
19. The role of senior executives and boards of directors is consistently identified as crucial to improving cultural and practice change in complaints management.

The subcommittee considered these findings and developed an encompassing set of recommendations aimed at addressing the underlying systemic issues. In making these recommendations, the subcommittee took into account human rights and ethics, best practice principles for complaint management, the issue of organisational culture and governance.

The recommendations are prefaced by a vision statement that identifies the key areas that inform the recommendations.

Vision statement:

The mental health service complaints system will ensure that the human rights of consumers and carers are upheld through a complaints system that is respectful, accessible, responsive, accountable and transparent. It will provide for genuine participation of consumers and carers in the development, implementation and review of the system, incorporate sound governance, enable advocacy and recourse to independent complaints mechanisms.

To support the attainment of this vision, the subcommittee for consumers and carers presents the following recommendations.

That the minister:

Approve the development and implementation of a Victorian public mental health services complaints management framework.

Recommendation 1: Develop a Victorian public mental health services complaints management framework.

The proposed framework will be consistently and flexibly applied to respond appropriately to diverse communities, embedding greater accountability at board and executive level. It will incorporate a requirement to review and report to the Department of Human Services and the Minister on trends, issues and service outcomes. The framework will promote a learning culture where complaints are perceived and used as an opportunity to improve service. Most importantly, it seeks to strengthen current practices.

Ensure the genuine participation of consumers and carers in the development, implementation and review of the proposed Victorian mental health complaints management framework in collaboration with mental health services.

Recommendation 2: Ensure consumer and carer participation and engagement.

Active consumer and carer engagement and participation is critical to the development, implementation and review of the proposed framework. It is important that this be affirmed by a ministerial determination that the proposed framework be led by consumers and carers, with the active participation and engagement of staff in the mental health sector. Processes must be established for this to occur. Services will also need to be strengthened to provide accessible and responsive internal and external advocacy for consumers and carers.

This determination will formally acknowledge the experience and value that consumers and carers bring to reform.

Prioritise the allocation of adequate financial and other resources to support the development, implementation and review of the proposed framework.

Recommendation 3: Ensure adequate resourcing and sustainability.

Adequate financial and material resources are needed to secure the implementation and ongoing functioning of the proposed framework. Funding will be required to provide:

- access to interpreters and bilingual or Indigenous mental health support workers to assist service users, family or carers wishing to lodge a complaint
- general training of staff in complaint monitoring and reporting
- dedicated and specifically trained complaints management staff across the service system and in the Department of Human Services
- a system for monitoring and enhancing the reporting of complaints.

Include as a Ministerial Advisory Committee priority in 2009 further collaborative work with the Office of the Chief Psychiatrist and the Office of the Health Services Commissioner with the aim of improving responsiveness to mental health complainants.

Recommendation 4: Ensure ongoing work in complaints management.

The complaints management project has highlighted the many avenues available to consumers and carers to make complaints. The Office of the Chief Psychiatrist and the Office of the Health Services Commissioner are the two key external avenues available to mental health complainants. Portfolio responsibility for these offices rests with different ministers and, given the significant vulnerability of people with a mental illness, it is critical that collaborative work be undertaken to enhance responsiveness to mental health complainants.

11. Conclusion

The Mental Health Complaints Review Project has captured a snapshot of complaints management processes in Victorian mental health services. Informed by several perspectives, the data gathered has provided an impression of a complaints management system requiring significant remedial attention. The key findings have identified a need for improved practice standards in the areas of visibility, accessibility and responsiveness as these relate to the experience of consumers and carers.

Consumers and carers, as users of mental health services, are uniquely placed to comment on their experiences of service delivery and standards. Their experience affords organisations an opportunity to reflect on the quality of the services provided. Good communication about care has been identified as critical and in many instances may render a formal complaint unnecessary. Indeed, most complainants simply want an apology, an explanation or some assurance that such things won't happen again. There was also a strong desire for consumers to be heard as individuals and not have their complaints dismissed because of their mental illness. Consumers and carers were more likely to accept and access a complaints system when they had had direct input into a service's complaints policy and operational standards.

Best practice literature on complaints management in health services notes that services benefit from the knowledge and experience of consumers when they adopt a collaborative approach. While a complaints system must respond to individual complaints, there is an organisational imperative to address systemic issues to improve the quality of services provided and protect against similar complaints by others.

Literature on complaints management identified several factors that render complaints processes less than optimal. These include resistance by staff to deal with complaints, which may be interpreted as criticisms of professional competence. Other staff do not see handling complaints as part of their role. From the perspective of consumers and carers there is the belief that staff will stick together and therefore complaints will not be treated impartially, or that individual staff will not act on complaints to avoid antagonising their colleagues. Consumers and carers also report a fear of being punished for complaining.

In considering mental health services as organisations, staff attitude is critical. As individuals, staff represent the point where organisational culture and personal practice intersect. Organisational culture is sustained and modified by practice, hence staff training has been identified as a mechanism to effect and sustain cultural change.

This project report has identified *what* can be improved in mental health complaints management (findings) and *how* this might be done (recommendations). Some of the recommendations can be implemented relatively quickly and others will take more time. Continued collaboration between consumers, carers and mental health services is necessary to improve the complaints management system.

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Appendix 1: Audit questions

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Name of interviewer:

Name of service:

Date of audit:

Interviewees/designation:

Items		Yes	No	NA	Relevant information
1. Commitment to consumers and quality improvement					
1.1	Is there a values statement on commitment to consumers?				Identify source/s, e.g. statement of patient rights
1.2	Is there a policy on management of complaints?				How is the policy accessed by staff?
1.3	Are staff able to describe the complaints process?				Determine percentage threshold. Check with a staff member to identify he/she understands the process. Debriefing sessions available to all parties (consumers, carers and staff)? Opportunities provided to consumers and carers for the use of advocates?
2. Accessible					
2.1	Is the complaints process well-publicised; posters, brochures?				Identify sources, e.g. waiting room Does the source list the other complaint avenues, i.e. health service liaison officers
2.2	Does the publicity include information in other languages?				Identify sources, e.g. waiting room
2.3	Is there a complaints box for lodging complaints?				
2.4	Is there a suggestion box for feedback about the service?				Identify sources, e.g. waiting room
<i>Does the information provided:</i>					
2.5	Contain information about how to lodge a complaint?				Verify source
2.6	Explain the investigatory process?				Verify source
2.7	Include information about mediation or advocacy?				Verify source, e.g. DHS Complaints
3. Responsive and timely					
3.1	Upon receipt are complaints formally acknowledged within five working days?				Is this identified within the policy?
3.2	Are there established timelines for complaint resolution - within 30 days?				Is this identified within the policy?
3.3	If the complaint has not been resolved within 30 days, is the complainant informed about the progress at each stage of the resolution process?				What does this involve?

4. Effective assessment and investigation of complaints					
4.1	Is there a tool or process that assesses the severity of risk associated with a complaint e.g. SAMS rating scale?				
4.2	Are complaints encouraged (policy) to be solved at the point of service by clinicians?				
5. Fair and impartial					
5.1	Are all complaints investigated individually without prejudice?				For clients identified as 'frequent complainants', is the process any different?
5.2	Are all relevant issues addressed in the resolution process?				Identify the last six registered complaints and follow through the issues have been addressed.
5.3	Is the investigative process documented?				e.g. written paragraph or flow chart, policy or operational manual.
6. Privacy and open disclosure					
6.1	Are managers able to describe how the confidentiality of the complainant is protected?				General vs specific
6.2	Are complaint records confidentially stored?				Identify whether copies are kept in multiple places?
7. Accountable and transparent					
7.1	Are all complaints recorded, tracked and documented?				Verbal vs formal?
7.2	Is staff delegated clear instructions and responsibilities for dealing with complaints?				Have staff been provided with guidelines on how to respond to complaints?
7.3	Does the service provide quarterly complaints data to the responsible authority?				Clinical (Health Services Commissioner), PDRSS (regional authority)
8. Training and education					
8.1	Are training aids available?				Identify the tools, i.e. intranet, policy
8.2	Is key staff (managers) trained in complaints management?				Formal vs informal
8.3	Is staff aware of the open disclosure policy and associated responsibilities?				Does the policy address this?
9. Evaluation and improvement					
9.1	Are there KPIs on complaints?				What KPIs are collected and how often?
9.2	Are KPIs on complaints routinely reported to the quality committee/executive?				Provides trend data. Request to view minutes/agenda with KPI detail
9.3	Is the organisation able to demonstrate service improvements arising from complaints?				
9.4	Have surveys/focus groups been convened to make recommendations for improvements to the complaints process in the past two years?				

Appendix 2: Focus group questions

Mental Health Complaints Project – focus group		
Name of interviewer:		Name of service:
Date of audit:		
Interviewees/designation:		
Items		Comments
1. Accessible		
1.1	Is the complaints process well publicised; posters, brochures?	
1.2	Does the publicity include information in other languages?	
1.3	Have you used a suggestion box for feedback about the service?	
Does the information provided:		
1.4	Contain information about how to lodge a complaint?	
1.5	Explain the investigatory process?	
1.6	Include information about mediation or advocacy?	
2. Responsive and timely		
2.1	Are you aware that complaints are formally acknowledged within five working days?	
2.2	Are you aware that complaints should be resolved within 30 days?	
2.3	Are you aware that the service should provide an update of where the complaint is at in the resolution process?	
3. Effective assessment and investigation of complaints		
3.1	Are you confident that the service is able to resolve complaints at the point of contact?	
4. Fair and impartial		
4.1	Are you confident that the service will respond to a complaint without prejudice?	
4.2	If you made a complaint, do you feel that your complaint will be dealt in a fair and impartial manner?	
4.3	Is the investigation independent of the service provider?	
5. Evaluation and improvement		
5.1	Have you seen the complaint KPI from the service?	
5.2	Have you been involved or are you aware of any focus groups that have been convened to make recommendations for improvements to the complaints process in the past two years?	

Appendix 3: Individual consumer and carer interview questions

Aim 1 - Gather information about their experience of mental health complaints processes.	
Q1.1	Have you recently (provide date) made a complaint to a mental health service or made a complaint on behalf of another?
Q1.2	Can you briefly describe the nature of the complaint/s?
Q1.3	What was helpful (positive) about the response you received?
Q1.4	What was unhelpful (negative) about the response you received?
Q1.5	Overall, how would you describe your experience of the complaints management process at the mental health service or PDRSS?
Aim 2 - Identify key practices and processes necessary for the successful implementation of a mental health complaints system.	
Q2.1	Having seen the <i>Statement of principles and processes</i> for complaint management, what do you think are the key areas that can be improved in: <ul style="list-style-type: none"> • Commitment to consumers and carers? • Accessibility? • Responsiveness and timeliness? • Accountability and transparency? • Effectiveness of the assessment and investigation of complaints? • Fairness and impartiality?
Q2.2	What will have to change to improve the complaint management process?
Aim 3 - Identify key practices and processes necessary for accountability and governance.	
Q3.1	Were you informed of your right to make a complaint?
Q3.2	Did someone from the service talk to you about the complaint?
Q3.3	After you made the complaint was it investigated?
Q3.4	How would you make the complaint process better?
Aim 4 - Identify potential synergies between public mental health services and stakeholders in complaints management and resolution	
Q4.1	How can public mental health services or PDRSS work with consumers and carers to better manage mental health complaints?

Appendix 4: Key stakeholder interview questions

Aim 1: Gather information about their experience of the mental health complaints processes.	
Q1.1	Have you recently (provide date) accessed/experienced a mental health complaints management process?
Q1.2	Can you briefly describe the nature of the complaint/s?
Q1.3	What was helpful (positive) about the response you received?
Q1.4	What was unhelpful (negative) about the response you received?
Q1.5	What are some of the issues (complaints process) that have been raised with you by your staff in response to complaints by consumers and carers of public mental health services or PDRSS?
Q1.6	Overall, how would you describe your experience of the complaints management process at the mental health service or PDRSS?
Aim 2: Identify key practices and processes necessary for the successful implementation of a mental health complaints system.	
Q2.1	Having seen the <i>Statement of principles and processes</i> for complaint management, what do you think are the key areas that can be improved in: <ul style="list-style-type: none"> • Commitment to consumers and carers • Accessibility • Responsiveness and timeliness • Accountability and transparency • Effectiveness of the assessment and investigation of complaints • Fairness and impartiality • Investigation process
Q2.2	What will have to change to improve the process (complaints management)?
Aim 3: Identify key practices and processes necessary for accountability and governance.	
Q3.1	What practices will have to change to improve the accountability of managing complaints?
Q3.2	What are some of your solutions to ensure the adequate governance of the complaints process?
Aim 4: Identify potential synergies between public mental health services and stakeholders in complaints management and resolution	
Q4.1	How can public mental health services or PDRSS work with your organisation to better manage mental health complaints?

Appendix 5: References from literature review

Jurisdiction	Name of document/paper
National	
Australian Council for Safety and Quality in Health Care, July 2005	Complaints management handbook for healthcare services Better practice guidelines on complaints management for health care services, July 2004
Health Care Complaints Commission, Safety & Quality Council, Health Issues Centre	Turning wrongs into rights: learning from consumer reported incidents, Summary, Annotated literature review, July 2003
Commonwealth Department of Health and Ageing	Complaints handling kit: residential aged care homes –resource materials
Standards Australia (Organisation generic principles)	Australian Standard: Customer satisfaction – guidelines for complaints handling in organisations (ISO 10002:2004, MOD)
New South Wales	
NSW Health	NSW Health: NSW Government response to the legislative council general purpose standing committee No 2 (GPSC No 2) – inquiry into complaints handling within NSW Health
NSW Health	Complaint management policy – PD 2006_073
NSW Health	Policy directive Complaint or concern about a clinician: principles for action, 30 Jan 2006
NSW Health	Complaint management guidelines 2006
NSW Health	Evaluation of the effectiveness of complaint handling and complaint reporting
NSW Health Care Complaints Commission (HCCC)	Guidelines for responding to a complaint
NSW Ombudsman	Compliments and complaints policy 2004
Tasmania	
Health Complaints Commissioner	The Health Complaints Act 1995 (Tas) commenced operation in May 1995 and establishes a system for assessment, resolution and investigation of complaints against public and private health service providers.
Queensland	
Queensland Government (Queensland Health)	Queensland Health (QH) Consumer complaints management policy, April 2007
Health Quality and Complaints Commission	Standards manual (designed to assist health service providers to understand their responsibilities under the Health Quality and Complaints Act 2006 (Qld)
Queensland Ombudsman	Queensland Ombudsman: Complaints Management Process – Phase 1 report (2005) Appendix 5: Developing effective complaints management policy and procedures
Queensland Parliamentary Library	A proposed new health commission for Queensland: Health Quality and Complaints Commission

Western Australia	
Department of Health	Complaint management process: Driving quality improvements by effective complaints management, 2004
Victoria	
Health Services Review Council	Guide to complaint handling in health care services, 2005
VGSOL	Administrative decision making in the public sector: managing legal risk – VGSO seminar series April 2007
Victorian Ombudsman	Good practice guide, April 2006
Victorian Public Hospital Patient Charter	The Public Patient’s Hospital Charter is in Schedule D to the Australian Health Care Agreement which exists between Victoria and the Commonwealth.
DHS complaints	AS ISO 10002-2006 Customer satisfaction: Guidelines for complaints handling in organisations
International	
United Kingdom	
UK Department of Health (DOH)	Making experiences count: The proposed new arrangements for handling health and social care complaints, Detailed policy background, June 2007
UK DOH	Making experiences count: A new approach to responding to complaints: A document for information and comment, June 2007
UK Health Care Commission	Is anyone listening? A report on complaints handling in the NHS, October 2007
UK	Getting the best from complaints: Social care complaints and representations for children, young people and others
World Health Organization	
World Health Organization	WHO Resource Book on Mental Health, Human Rights and Legislation p. 70 ‘Complaints and remedies.’
New Zealand	
Health & Disability Commissioner	Patients rights in New Zealand: a tool for quality improvement? Paper delivered to 3rd national health care complaints conference Melbourne March 2001
Health & Disability Commissioner	Complaints: the good, the bad and the ugly, The First NZ Health Care Complaints Conference, Hamilton, 22 April 2002
Health & Disability Commissioner	A consumer’s guide to the Health & Disability Commissioner (2002): Your rights when using a health or disability service in NZ and how to make a complaint.
Health & Disability Commissioner	Broadcasting complaints lessons
Health & Disability Commissioner	Complaints answers to some frequently asked questions
Health & Disability Commissioner	Simple resolution of complaints referrals to advocacy
Health & Disability Commissioner	Good news about complaints
Canada	
Quebec Ombudsman	A legitimate, credible complaints office: complaints processing in governmental organisations, 2001
USA	
New York State Ombudsman	The complaint

Appendix 6: List of key stakeholder organisations

Office of the Health Services Commissioner

Office of the Ombudsman

Office of the Disability Services Commissioner

Victorian Mental Illness Awareness Council

Action of Disability within Ethnic Communities

Carers Network

Mental Health Legal Centre

VIC SERV

Mental Health Review Board

Office of the Public Advocate

Office of the Chief Psychiatrist

Multiple and Complex Needs Initiative Panel

Health Services Liaison Association

Victorian Civil and Administrative Tribunal

Appendix 7: Membership of the Ministerial Advisory Subcommittee for Consumers and Carers

(October 2008)

Role	Stakeholder category	Member name
Subcommittee Chair	MAC Chair	Mr John McGrath
MAC members	Director, Victorian Mental Illness Awareness Council	Ms Isabell Collins
	Chief Executive Officer Victorian Mental Health Carers Network	Ms Julien Leith
	Chief Executive, Mental Illness Fellowship of Victoria	Ms Elizabeth Crowther
	Chief Executive Officer, Western Region Health Centre	Ms Clare Amies
	Consumer consultant	Ms Wanda Bennetts
	Chief Psychiatrist	Professor Kuruvilla George
	Carer Consultant, Victorian Trans Cultural Psychiatry Unit	Ms Marie Piu
Co-opted members	Executive Director	Associate Professor Alex Cockram
	Psychiatric Nurse Consultant, La Trobe Regional Hospital	Ms Linda Curtis
	CEO & member, Nurses Board of Victoria	Ms Petrina Halloran
	Health Services Commissioner	Ms Beth Wilson
Other representatives	Department of Human Services	Ms Veronica Spillane, Manager, Office of the Chief Psychiatrist
		Mr Jeffrey Chapman, Snr Project Officer
Secretariat	Department of Human Services	Ms Joyce Goh, Manager, Service Quality
	Department of Human Services	Mr Keir Saltmarsh, Senior Program Advisor

Appendix 8: Summary of recommendations by project participants

The following points represent comments or ideas put forward by project participants during the information-gathering stage.

Individual interviews

Comments

- ‘Perhaps rather than me writing the letter, talking to someone face to face. Whether it might be to a group of consumers, but talking to someone face to face.’
- ‘Perhaps have a little leaflet by your bed.’
- ‘I think that particularly staff training [would improve the complaints process].’
- ‘Perhaps consumer consultants can come and tell people about their rights and responsibilities. I wasn’t even given the information pack when I came in, not that I was in the state of mind to read it.’
- ‘Give value to the complaint because it is not easy to complain.’
- ‘Have an encouraging atmosphere where they can be listened to and be able to tell their story without judgement or fear of negative implications. So it probably sounds too simple but listening with empathy.’
- [What in your experience needs to change?] ‘Everything. Absolutely everything. Number one they have to acknowledge that the patient is making a valid complaint. If the patient is in an unwell mental state the fact that they are making a complaint does not make the complaint invalid.’
- [Do you think if the statement of principles were adhered to it would have reduced your...?] ‘This is so far away from anything I saw, felt or was treated like in that place it’s not funny.’
- ‘I think that first of all mental health patients need to be recognised as equal human beings with valid issues and complaints like any other consumer in any other medical service. Number two they have to be able to go to a totally independent authority so that there is no bias, a panel or a board so that the people they are complaining to act upon the complaint as quickly as possible.’
- ‘The timing is essential because the complaint becomes an illness of its own.’
- ‘It does need to be more accessible, there needs to be someone there at all times who is accessible.’
- ‘... some sort of support person for the patients. Someone who is working for the patient’s wellbeing rather than focusing on a psychiatric condition and medication. So, I think the person in there should be trained in, I guess, social work, and should be compassionate. And I mean some of the complaints I am sure could be resolved just by having someone to talk to about what’s going to happen to you.’
- ‘Accountability. One of the things that they say about mentally ill people is that they have delusions of grandeur that they are next to God. And I tell you what that’s what most psychiatrists are like. They think that they are above everyone and maybe some of them have to be pulled down to earth and get their knees chopped off, not literally, to show that they are

not infallible. They believe themselves to be above the law and in fact they are in reality. And perhaps that's what's got to stop.'

- 'Listen to people. With your ears. Not your bloody degrees in psychiatry. There's more to life than what is in the textbook.'
- 'Yeah whether or not there can be resolution or the consumer gets what they want. Just to know it's been followed up; it's been investigated. I think it's really important.'
- 'That someone comes in and is available to talk to a patient one on one because, as I said, some of this stuff is really traumatic, and follow it through. That's not one person throughout the whole service I think that's a body of people that are trained and have the capacity to do just that. And will be taken seriously. I am not saying that you have to scare the nurses and the doctors but there needs to be some sort of consequences for what's going on...'
- 'I suppose from this level if there was some sense that there would be accountability when things go wrong for clinicians on the ward.'
- 'There must be someone who actually owns this process [of complaints] and who is actually accountable for it'. There might be a separate area in the organisation that receives regular reports on the complaints data, which can focus on certain types of complaints that come out, and which is empowered to take initiative to actually address shortcomings that have been identified. In other words, 'the complaints system is basically a medium for improvement, whether it be process improvement or case management improvement'.
- 'Open door' policy is ideal so concerns can be resolved as quickly as possible; however, for that to happen 'all staff need to have the appropriate attitude'.
- 'There need to be the appropriate processes that support (staff) and the behaviours of their management need to exude ... the behaviours that are required within the organisation.'
- Issues of a minor nature with no risk attached need not necessarily be recorded.
- It should be acceptable to lodge a complaint via the telephone and have it recorded and actioned in the same way as a more formal complaint.
- The more complaints that are recorded the better it is as it 'enables management to get a far more effective overview of the situation and ensure that policies and practices are put in place.'
- There 'needs to be a measurement around it. Positions and people need to be accountable and there needs to be recognition and rewards systems around that' This will help promote 'a sense of pride in effective management of complaints.'
- 'The person lodging the complaint 'needs to be assured that it can be handled quickly, compassionately, effectively and with an appropriate outcome.'
- The 'criticality' of the situation also needs to be considered, and guidance given about how timelines may need to be adjusted to be appropriate.
- All complaints should be 'recorded, tracked and documented.'
- In addition to points made previously, 'it requires effective administration to put it in place', needs to be seen as being 'not negotiable', and to have a realistic timeframe put on it.

- In addition, it is better to operate at a system-wide level, that is, be across the whole of the health system. The system could be ‘actioned locally but monitored centrally at a state or national level’
- ‘There also needs to be an ‘escalation process’ so that a person can actually jump over some steps in the process so as not to get bogged down in it’
- ‘Hospitals are not necessarily set up to handle the quality of the input that comes in (for example, from members on consumer and carer advisory groups).’
- ‘Monitoring could happen through random “visits” or inspections akin to “mystery shoppers”’.

Ideas

- An independent statutory body (committee) that included consumers, case manager, psychiatric nurses or occupational therapists but not a psychiatrist be established to review complaints as the responses received from the Office of the Chief Psychiatrist, Health Services Commission and the local service were unsatisfactory.
- All complaints should be handled by a solicitor or advocate because of the complexities of the Mental Health Act.
- Mental Health Act needs a complete overhaul.
- Need to treat carers and consumers as an asset, not as a liability.
- If the services were more honest, and try to resolve concerns, there would be less complaints.
- Having forums that provide the opportunity for carers and consumers to speak is very important, such as the complaints review project.
- Complaint protocols to be followed to enable timely service response to complaints to be achieved.
- Clinical notes to be kept in a diligent manner to ensure that consumer rights are upheld.
- Communication between the service and the carer to be maintained at all times.
- There needs to be standardisation of quality practices across clinical services.
- Carers need to be informed of their right to make complaints by the service.
- Services need to be genuinely committed to carer participation, that is, to illustrate this commitment by listening and valuing carers’ concerns.
- There needs to be appropriate, standardised job descriptions for nurses.
- A tiered approach is important, and there needs to be the ability to ‘fast track’ a complaint. There needs to be some immediate reaction within 24 hours, especially in relation to a serious complaint.
- In addition to the points noted in the *Statement of principles and processes*, there needs to be a point about ‘resolution’ which is what really motivates people to make a complaint. It needs to go further than an apology.
- Systemic steps must be taken to ensure that the same issues won’t arise again.

- The carer was informed about his right to make a complaint when contacted by the complaints manager, but could not recall seeing anything on the ward about making a complaint.
- It is important to continue opportunities of consumers and carers to be involved at various levels, for example, consumer advisory groups.
- There is a need to ensure sustainable change through effective policy and procedures, effective job descriptions, and monitoring of those.

Focus groups

Comments

- ‘I guess they can do what they like to you when you’re certified.’
- ‘Everyone should get a book on your rights/complaints/information on the unit or ward.’
- ‘Employees [staff] of the service should remind/inform people about [the] complaints process.’
- ‘There should be an informal complaints process before making a formal complaint.’
- ‘It’s [complaints process] not clear enough.’
- ‘Few more accountability measures in place such as better follow ups etc’
- ‘There should be a consumer/staff meeting to update us all on the complaints process.’
- ‘The staff felt threatened by my comments and retreated to the office.’
- ‘There should be a staff member sitting in at the consumer meetings.’
- ‘The staff need to be approachable.’
- ‘A regular meeting to inform us.’
- ‘The advocate/consumer consultant is a bridge and we need better access to that. Also an expansion of their hours. The consumer consultant was the only one who has ever approached me and asked.’
- ‘Make it [complaints process] easier.’
- ‘Posters, information posters on the process with different languages.’
- ‘I’d like more information about advocates and support. Phone numbers and contacts.’
- ‘The process should be explained when you’re “compos” – not ill or too drug damaged to react.’
- ‘If you’re not compliant, they will make you compliant.’
- ‘If you’re a cleanskin you’re gone. Before you know it you’re full of medication – it takes years to get over it.’
- ‘It hasn’t changed in eight years – it sucks.’
- ‘There are too many staff rotations and changes that cause problems.’
- ‘There has to be enforcement and consequences so that staff follow procedures and are accountable.’
- ‘Have an independent advocacy service with a person on each unit to help consumers and inform them.’

- ‘Establish an independent body with some consumers involved.’
- ‘There needs to be a change in the culture – the culture is wrong. There’s just lip service with no respect.’
- ‘The process should be transparent.’
- ‘There has to be some government enforcement of rights and complaints.’
- ‘The community visitors should be replaced with new ones – they look mute and they just run straight to the management with the info from the consumers they talk to.’
- ‘It would be good if outcomes from this [project] were fed back to us consumers.’
- ‘Most people [staff] here are good. They do make mistakes from time to time but that’s just human.’
- ‘It would be good to have a ‘designated person’ that you went to. An independent person that you could talk to.’
- ‘There needs to be a policy with a clear pathway for complaints.’
- ‘Improve communication and contact with us to make sure everyone is OK – especially those that have trouble with confidence etc.’

Ideas

- Mediation should be available.
- The group recommended the establishment of an independent committee to hear complaints and someone to help you with the process.
- Complaints should be responded to, not ignored.
- There needs to be a six-monthly meeting with consumers to update consumers about service procedures and policies.
- More access to consumer consultants.
- The consumer representative should have access to staff meetings.
- An information pack for consumers who were new to the service was recommended by the group. This should include information on consumer’s rights and the complaints process.
- Some consumers asked for better help with literacy issues.
- There were many comments that staff should assist unwell consumers who want to make a complaint, for example, ‘Someone to sit down and talk to me about it – when you’ve got other voices in your head it’s hard’.
- All participants stressed the need for an independent person on the ward to help them with complaints such as a ‘mental health advocate’ or ‘... an independent person to help with the process.’
- The service needs a noticeboard on which complaints information can be advertised.
- Carers should automatically be given a carer information kit containing information on how to complain, who is responsible for complaints management at the service, what the process is, etc.

- Information needs to be available in multiple languages.
- Information should be written in straightforward language and be easy to understand.
- The information given to consumers (about consumer rights, complaints processes etc.) is not matched when it comes to carers, who don't receive equivalent information.
- The individual responsible for complaints management within the service
- should be independent of the service (and this fact should be communicated to carers so that they feel more confident about making a complaint).
- Services need to have complaints procedures in place, written out in black and white, to which staff are held accountable.
- How would the service know whether the complainant received acknowledgement for their complaint or not – where is it recorded, and where is the accountability? These issues need to be addressed.
- Complaints procedures should mandate regular updates to carers regarding what is happening with the complaint and staff should inform carers of the final outcome of their complaint.
- Something tangible has to change in response to complaints – just talking is not enough.
- Staff need to engage carers and listen to them in order to stop problems before they get to the point where a complaint is lodged.
- Carers should be provided with access to an advocate.
- Interpreters should be available to carers.
- Carers need more input into the running of the service and the mental health system generally – carers need to be represented at the highest level.
- Services need appropriate funding and resources to allow them to work with carers and resolve complaints and problems early, or prevent them from occurring at all.
- A list of service staff and their positions as well as the various departments should be written up and made available to carers and consumers so that they know who is who, who does what and who is in charge of what in the service.
- There should be a specific complaints department and a nominated complaints officer.
- Posters should be put up in the service detailing how to make complaints and what complaints protocol is.
- Service funding should be conditional on certain outcomes being met – this needs to be DHS-driven.
- Provision should be made for carers who may need assistance (advocacy) to formulate written complaints.
- Carers need to be told who to contact to complain.
- Responses to complaints should be written, dated, and should also outline the proposed actions to be taken from here.

- Complaints should be registered and the processing of complaints transparent – e.g. information on how many complaints have been received, how many resolved, etc. should be available to interested parties.
- There is a need for written confirmation, particularly if the carer cannot be contacted by phone.
- There is a need for an impartial complaints body outside the service.
- Information should be advertised by the service so that carers know that a process exists. On first contact with the mental health service carers should be given an information pack with general information and complaint information.
- Carers should be told of the existence of the Ombudsman.
- There needs to be a complaints box at the inpatient service.
- There should be a contact person specifically for complaints (and carers need to be told who this is).
- Information only gets passed via word of mouth in carers group – this is totally inadequate.
- Carers and consumers should be able to complain through the same channels as general health patients.
- There is a need for carer consultants to help advise carers on the complaints process.
- Services need to view complaints and feedback as an important part of the process of service improvement.
- Make available to carers documents such as the *Statement of principles and processes* for complaint management outlining complaint processes best practice.
- Complaint forms should be available at the front desk.
- Folders of information – including complaints processes and forms – should be given to all carers who come into contact with the mental health service as soon as possible (e.g., immediately upon admission).
- It is important that carers are properly informed of their right to complain.
- Carers need to be given documents detailing where to go to make a complaint, who they can contact, what phone numbers they should call, etc.
- The service needs to be accountable for managing complaints – at present accountability is non-existent.
- Both complaint information and complaint forms need to be written in simple, easy-to-follow language.
- Many complaints are made by phone – these need to be acknowledged as well.
- When it comes to carer-sensitive practice. The service is good at paying lip service to the idea, but there is never any action – this needs to change.
- Communication was identified as a problem with staff for whom English is not a first language.
- Participants noted the need for some complaints to be dealt with ‘then and there’ as well as the need for more structured and drawn-out complaints processes.
- The service should acknowledge the complaint in writing.

- The service should provide a schedule for the resolution of the complaint.
- Carers and consumers should be given an information pack (including complaints information) when they enter the service.
- Carers and consumers should be informed of their right to complain.
- A newsletter with a carer focus would be a good way of disseminating relevant information to carers.
- A carer group that meets regularly would be helpful.
- It is important that people are not made to feel they have done the wrong thing by complaining.
- For two participants, the best way to achieve results is to handle issues informally by working things out directly with staff members.
- Carers need to be made aware of complaints processes.
- Carers need to be given complaints policy documentation.
- Brochures outlining how to make a complaint and what the process is from there need to be readily available, not hidden away in the office somewhere.
- Information on complaints could be disseminated through carer groups and newsletters.
- There should be more efforts to involve consumers as well as carers in processes of complaint and feedback.
- Mental health bodies that can help with complaints need to be made known to carers.
- Managers of services need to be available to carers to hear feedback and complaints.
- Improvement has already started with the appointment of a new CEO.
- Staff need to be trained to communicate complaints appropriately to others in the service – the head worker, the CEO if necessary.
- Comprehensive information on the complaints process should be disseminated to carers.
- Information on complaints needs to be clarified – who does what, who you should see in the service, what you can expect of the process, etc.
- Information should be written in plain English and be easy to understand.
- The feedback/complaints form needs to have questions allowing for a structured response, rather than just a blank space for you to write in.
- The feedback form needs to be complaint-oriented, and inform carers of their right to complain.
- Complaints need to be acknowledged in writing by the service.
- It needs to be made clear that there will be no backlash against carers or consumers for complaining.
- Complaints should be addressed immediately.
- Carers should be given an information pack (including complaints information) to take home from the service, rather than be expected to go through all the brochures available then and there.
- Staff should speak to carers in plain English.

- There needs to be greater communication facilitated between carers and clinicians; this would help prevent problems reaching a stage at which formal complaints are made.
- It is important for carers to put their complaint in writing so that there is a record of the complaint.
- The status of complaints should be reported regularly at staff meetings – what the nature of the complaint is, what has been done to try to resolve it, what the next step will be, and so on.
- It is important that complaints go to the Continuous Improvement Committee, and that they get passed on to management if they are not resolved.
- Carers should make themselves available to be involved in panels or committees dealing with complaints issues.
- If the complaint is not satisfactorily resolved, the CEO should bring in an independent mediator.
- Complaints guidelines should stipulate that no complaints are trivial, and they all should be tabled – staff need to be held accountable to this standard.
- Complaints of the service need to be properly documented – how many complaints there have been, how many have been resolved, etc.
- Services need to take feedback on board in order to improve.

Key stakeholders

- Each MHS to have an identified contact person for complaints.
- Person needs to have authority and also the administrative resources to do the job properly.
- Prefer an integrated complaints management system rather than a separate MH complaints process.
- There then needs to be an effort to improve accessibility to the system as well as a much more transparent process.
- Complaints should have their own key performance indicators, such as timelines for initial acknowledgement of complaint and for resolution.
- Staff need to be trained about complaints and be included in complaint feedback.
- KPI for complaints should be reported to the board of directors.
- Governance sits with the board of directors.
- Board and CEO relationship is crucial to ensuring a flow of necessary, relevant and meaningful information.
- Boards needs to ensure that:
 - complaint policies are in place
 - policies are up to date
 - the handling of complaints is properly resourced
 - polices are being implemented and periodically reviewed.

- Governance also involves standards of documentation and good record keeping (e.g. complying with relevant legislation) as this protects staff and the organisation.
- Local level staff need to know where to direct complaints and how to initially respond at point of service.
- Feedback should be given to all staff involved in a complaints process.
- Need to promote a culture of respect for dignity of persons and zero tolerance for inappropriate behaviour.
- Important to see that complaints result in changes to practice, so that it can be seen to be meaningful to complain.
- Need to move away from complaints equalling defensiveness to complaints equalling opportunity for service improvement and quality assurance.
- DHS would be an appropriate leadership body in complaints management policies and practices.
- There are so many access points into the mental health system that it is often too complicated for the public to know where to go when dealing with complaints, particularly when they may also be very unwell. This also relates to complaints fatigue, people get transferred around by phone to so many different points across different services it takes a lot of effort to persist and some may simply give up.
- There needs to be a much more integrated approach to handling complaints across the multiple pathways and process by which they are made. It should not be for the public to have to negotiate this morass, instead, mental health and related relevant services should ensure a seamless system for complaints management.
- In terms of accountability there needs to be strong leadership from a key sector body like the Office of the Chief Psychiatrist. It can set and monitor standards and collect and track associated data on performance regarding complaints management.
- In terms of a map or visual representation, imagine a dartboard with a bullseye: the OCP and sector can be the first level of an integrated system responsible for managing complaints; beyond that would be the Health Services Commission with a larger brief to look at other systemic issues, then the Ombudsman's Office/VCAT with an emphasis on process, natural justice, procedure and administrative and rights law.
- As there are a variety of service and funding models a mental health sector-wide approach to complaints management is required so that there is uniform coverage with agreed principles.
- Another issue this raises is the problematic and contestable split between public and private provision of mental health services. We know that over the recent past, the distinction between public and private has become more blurred, for example, a private psychiatrist who bills Medicare is in fact in receipt of substantial monies from the public purse.
- Instead of looking at the legal status of entities providing services, which subtends the public/private split, it might be better to follow the money trail; for example, investigate where the bulk of funding is coming from, and then make the relevant rules hold. This just underlines different

ways of thinking about the distinction between public and private provision of mental health services and the importance of a general coverage of administrative law.

- Usually, the Office of the Ombudsman does not deal directly with individual mental health services, but with the Health Services Commission and the Office of the Chief Psychiatrist.
- There needs to be a much more systematic and integrated approach to the management of complaints across the different service types in mental health, one that could begin with identifying systemic issues in complaints management.
- Needs to be clear responsibility given to staff and the opportunity to improve services. If the complaint is not successfully resolved, there needs to be an independent review.
- There also needs to be independent auditing of complaints files, policies and procedures/ processes to ensure they result in service improvement.
- Issues of governance sit with boards of management, who are obliged to ensure that there exists a really effective complaint identification and resolution process.
- Data should go from the CEO to the board for evaluation to ensure any systemic issues identified are properly addressed.
- The board should not look at individual complaint issues (it is not itself a step in the complaints management process – it is not a manager, but exists for the sake of governance).
- There needs to be a more integrated mental health service system, and a clear access point and pathway for complaints resolution.
- Investigative resources and skills.
- Genuine independence in investigations.
- Do not stigmatise the mentally ill with the name liars when they make a complaint.
- Change in the culture around complaints – from a defensive attitude to one that sees them as potential improvements to services.

Transparency and accountability

- The complaints system must be transparent and accountable if it is ever to be effective.

Effective assessment and investigation of complaints

- There must be adequate resources to allow proper investigation and that investigations be fair and impartial.
- In order to do this a fundamental attitudinal change is required. We need to move from a culture of defensive reasoning, which looks at protecting the agency, to one where we look at the root cause of a complaint. In order to see just how bad current culture is about complaints, we only need to look at how whistleblowers have been treated.
- Make changes to the Mental Health Act.
- Make changes to the Health Conciliation and Review Act.
- Health services must be made to attend conciliation.

- Needs to be more prescriptive guidelines in the handling of complaints.
- More training in how to conduct mental health investigations.
- Complaints officers must have the status and resources to be able to conduct proper investigations of complaints.
- Each service to collect data on the number, type and outcomes of complaints.
- Data should go to the board who should consider the data from the point of view of identifying systemic problems and implementing solutions from the perspective of quality assurance in the organisation.
- Annual reports on quality assurance should go to boards and the Office of the Chief Psychiatrist.
- Governance is a matter for boards, who should be showing leadership and cultural change from the top down. The role of the CEO is crucial in ensuring that boards are given meaningful information in a timely manner.
- Mental health services must be more open about the fact that problems exist.
- The fact that problems exist and need addressing should not be taken personally, but seen from a professional perspective, as an opportunity to improve performance and service responsiveness.
- Given the power that is invested by the state in the mental health area, such as involuntary treatment, seclusion and the like, the state can intrude directly into people's lives – this needs to be balanced by caution, transparency and accountability for how vulnerable people are treated.
- There needs to be education aimed at CALD clients that looks at cultural impediments to accessing complaints processes as well as some basic, introductory material on the theory and practice of rights.
- The biomedical model just focused on the illness not the whole person, and certainly not, the persons in their social environment, need to expand the biomedical focus by taking in sociality and environment, and families are a major part of this.

Commitment to consumers and carers

- Needs to be a strong commitment to treatment that includes a place for families, there must be effective communication with families and caregivers.

Fairness and impartiality

- There needs to be better resources available to existing independent bodies, such as the Office of the Public Advocate, who seem to be falling down in responding to complaints and in addition, an independent advocacy service for mental health complaints that would take the work off family members by ensuring complaints are properly followed up.
- Better training for mental health staff might result in fewer complaints.

- Needs to be a model for collaborative practice in mental health, a model for engaging with families in the therapeutic process we need a model in which clinicians can work with families.
- A formal independent statutory advocacy service, under a 'rights umbrella' that could undertake work to make governance in mental health services better via an educative element.
- An independent, statutory Office of the Mental Health Commissioner that would include within it a suitably resourced advocacy branch and a capacity to properly conduct investigations into complaints.
- Mental health services really need to take the Disability Services Act and its ethos as a model for service provision and clinical practice, such as working towards wellness.
- Change in culture, so that complaints are seen not as threats to an organisation, but as an opportunity for quality assurance and service improvement.
- Links to telephone help lines could add another dimension of data relevant to complaints. Identified issues could then be addressed via ARAFEMI PDRSS network.
- Coordinate the exchange of complaints data across PDRSS sector, to ensure that it is used to identify systemic issues and provide evidence for the need for service improvement.

Accessibility

- Complaints documents written in plain, simple language. Avoiding remarks in reports such as describing a patient as 'promiscuous and malodorous' need less value laden and more objective language for dealing with complaints.

Commitment to consumers

- Commitment to consumers will be better encouraged and protected if it is enshrined in legislation. Link mental health complaints more directly to human rights, such as the Charter. For example, the Northern Territory Mental Health Act enshrines service principles including complaints within the Act.

Fairness and impartiality

- There needs to be better training for complaints officers in how to conduct investigations.

Responsiveness and timeliness

- Complainant must be listened to and not pathologised.
- Complainants must have direct access to complaints officers, and their training is crucial to the success of the complaints management system.
- Have complaints management subject to spot auditing, a fine-toothed comb approach. This should be carried out by an independent inspectorate.
- There must be regular reporting of complaints statistics to the governing boards of institutions (standing item).

- A Consumer Advisory Group (CAG) should receive reports on complaints data and have input into systemic responses.
- There must be a higher status and more authority/resources given to complaints officers in AMHS and PDRSS – complaints need to be seen in the broader context of quality or service improvement.
- Could make a list of AMHS and PDRSS complaints contact officers on the DHS mental health website it could include:
 - assistance with complaints
 - flow chart of complaints process with timelines for actions
 - likely outcomes for conciliation in typical circumstances
- As there are many access points to services and different types of complaints have to go to different places, it is a complicated landscape to navigate, therefore, there should be an oversight from a main agency that can coordinate with other agencies in managing cross-agency complaints.
- As there is not a capacity in Legal Aid to assist in civil matters, a brokerage model for mental health clients to provide money to prosecute civil claims for damages.
- Consumer Advisory Group (CAG) should have the complaints data and input into any improvements/changes in complaints management systems.
- Caesar investigates Caesar – it must be a requirement that complainants are informed, at the time of their making a complaint, that there are external bodies that they could take the complaint to.
- There should be a statutory requirement for complaints data to be reportable to governing boards of institutions, data should be publicly reportable. This data should also be supplied to the Office of the Chief Psychiatrist
- There appears no feedback on how complaints are being handled and their outcomes: a central and available data base should be established on complaints. It would contain:
 - type of complaint
 - number of such complaints
 - outcomes of complaints
 - data would be used to identify trends and assist in addressing systemic issues.

Commitment to consumers and carers

- Need to ensure an ethos and style of practice that lets the client be the expert on the client, a way of working with the client that encourages individual choice and that works proactively with clients.
- Working proactively means that potential complaints can be identified as problems or issues and addressed before they become complaints for example re-jigging a personal care plan to allow a new activity, or more of an activity at a different time.

Fairness and impartiality

- Could be hard to secure fairness and impartiality in a small organisation. What are the mechanisms by which the PDRSS sector can ensure fairness and impartiality of complaint investigations?

Accessibility

- Goes to the visibility of the complaints management process and how well it is communicated to clients.
- It is important to reach all participants in a PDRSS when it comes to complaint management, irrespective of the particular program they may be engaged in.
- Is there a basic orientation for new members to the service?
- Is there an induction kit that is given to new clients of the service do staff take new clients through the kit, explaining it to them?
- Forums could be held at which consumers and DPRSS staff could attend – these would aim to educate both groups about the complaints management process and capture feedback from consumers to improve the service.
- There needs to be a consistent approach across the sector to managing PDRSS complaints.
- With agreed processes a baseline could be established to measure improvements/declines in practice.
- Should be standard training for complaints management across the PDRSS sector.
- Right from the start, consumer input and feedback should be used as an integral part of service development. They can be involved in formulating policies and practices and then in testing them to refine the complaints management system.
- PDRSS could put their complaints management systems and related policies on the VIC SERV website, available in easy, user-friendly format.
- Key performance indicators for complaints should be reported regularly to the board.
- Systemic issues identified should be accompanied by the steps taken to redress the issue so that it does not happen again.
- Needs to be a leadership approach from the top down for accountability in complaints management.
- How well do boards really understand their responsibilities and liabilities around governance generally?
- A risk profile system needs to be build into the identification and management of complaints, among other reasons, to help ensure an adequate response to identified systemic issues.
- There are a number of bodies that currently work in the area of accreditation for example, QICSA, ISO, ACHS (Australian Council of Health Care Standards). These would have material on best practice around governance and complaints management. These could be used as the basis of a sector-wide training package, developed and rolled out by VIC SERV.

Commitment to consumers and carers

- Improved understanding of services staff and government of the value of complaints as a mechanism for improving services.

Accessibility

- A clear and transparent pathway for complaints.

Effectiveness of the assessment and investigation of complaints

- Independence of the complaints resolution process: compare the independence and powers of the Health Services Commissioner with the perceived lack of independence (from DHS) of the Office of the Chief Psychiatrist.
- Communication could be improved, especially between different CALD groups and better interpreter resources.
- Needs to be a more coordinated or integrated approach to the care, for example patient are conceptually split up into physical and mental. Thus one can find a patient whose mental health needs are being addressed but is suffering form poor oral health.
- Workforce issues also require addressing, as continuity and availability of services is at issue:
 - more continuity of care in regions
 - more turnover of staff/clinicians in the city/inner suburbs
 - examine protocols between CAT teams and police, as there is more frequent use made by CAT teams and police in potentially violent situations, as this is very traumatic for patients
 - need to pay attention to the experience of family members who know about the illness and its effects
 - do not pathologise the complainant by making each complaint a symptom of psychic malady
 - psychiatric patients could be better catered for in emergency departments.
- Need to have a better way of ensuring a timely access to a second psychiatric opinion in a mental health service.
- MHRB has no powers to give sanctions or follow up on whether services have complied with its findings, such powers could be given, for example, a statutory obligation to report to the Parliament via the Minister on the content of complaints.
- There are lots of informal complaints, these need to be captured and treated seriously like formal ones, yet they are not viewed with the same degree of seriousness as are formal (written) complaints: there must be developed a way of capturing and adequately addressing the large body of informal complaints.
- A worthwhile model is to investigate the complaints process in Great Britain. A number of roles, including examining complaints, is undertaken by a (separate) arm's-length, independent statutory mental health Acts and welfare commissions.

- There may be value in considering a complaints/quasi-complaints role for the board, or a requirement to report to the Minister/Parliament on patients' complaints in hearings.

Commitment to consumers and carers

- All the proffered principles for complaints management are appropriate, but they will be ineffectual unless underpinned by the fundamental value of commitment to consumers and carers. Otherwise, key changes in culture and practice will not be made appropriately. A commitment to consumers and carers is necessary for cultural and attitudinal change, for example, the change from seeing complaints as 'negative' to one that sees complaints in the context of service improvement or quality assurance. Such attitudinal changes are probably behind differences in restraint and seclusion between services.

Process

- Consumers need to be assisted in making formal complaints
- The process needs to be transparent across different services and also needs to be standardised.

Quality

- The handling of complaints is itself one measure of quality and we should look for an attitudinal shift from seeing complaints as 'bad' or 'negative' to seeing them as opportunities for service improvement.

Communication

- Is crucial for better practice generally in mental health services, patients need to be related to personally, and taken time with, this is not a matter of resources as much as a question of the way or style in which staff relate to patients.
- Leadership is important and must be led from the top down; support is important to foster change. It is also hard for good people to work in services imbued with a bad culture. This is expressed at staff level too, with high turnover rates.
- Community education about mental health is important because it is still seen as a taboo area.
- Boards need to foster community engagement around attitudes to mental health.
- Boards need to rethink how they sit within their local communities.
- Boards are the seat of governance for mental health services.
- Boards should receive quarterly quality reports and annual reports and examine complaints management from a systemic perspective with an eye to improving service quality.
- The issue of a split between the management of health versus the management of mental health complaints needs to be looked at. One integrated system would seem more efficient.
- It is important that while dealing with complaints from a systemic perspective, the information provided to boards is meaningful and relevant, not filtered out.

- Ensure that materials on complaints and rights that are targeted to consumers is appropriately written to foster understanding.
- The experience of consumers and carers should be at the centre of service, that's why mental health services exist. One obvious implication would be engaging consumers/carers in service development and assessment.

Accessibility

- A proper complaints system must be accessible to users of the system and time lines for responses to complaints should be clearly available and the service bound to them.

Accountability and transparency

- The complaints management process should be accountable to service users and include CALD and other culturally appropriate training.
- Services should ensure a complaints package is given to all new service users that clearly sets forth the complaints process, associated timelines and contacts for assistance when making a complaint.
- Posters advertising the process should be prominent
- Contact information should include a telephone number and position title for assistance.
- A review of extant policies and practices against the Australian Council of Health Care Services is required.
- From a systemic point of view, all health services must provide HCIP data to the Health Services Commissioner, it is therefore important that strong links exist between health and mental health complaints mechanisms in services that have a split system of mental health versus health complaints.
- There should be an independent scrutiny of boards, for example, a broadening of the remit of OPA or the Health Services Commissioner to examine complaints data from individual boards and follow up on how complaints have been responded to.
- Better reporting up to boards of management about complaints and an emphasis on the systemic dimension of complaints with a move away from seeing complaints as 'negative' and thus to be defended against to one that sees them as opportunities for service development and quality assurance.
- Need a system that captures informal complaints and treats them as being as serious as formal or written complaints.
- Documentation needs to be of a good quality and simple (not too onerous) to use.
- Need a way of capturing the complexity of a complaint, for example, where one complaint may involve several agencies in an attempted resolution.
- A move from focusing on substantiation of complaints (legalistic and adversarial) to one of resolving complaints.
- Services need to investigate complaints in an open and transparent way.

Accessibility

- Services must be accessible to clients: access to services has been difficult for some patients.

Responsiveness and timeliness

- More standardised processes and integrated service responses, as at present, services have different funding models, deliverables, cultures.
- Workforce development and accreditation for drug and alcohol services.
- Services need to be better integrated to respond to client needs.
- When mental health service patients enter the treatment system, they should be provided with succinct and accurate information on the most likely outcomes of different treatment modalities for different conditions, so that patients can make informed choices about treatment options and know what to expect.