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# Mental Health Complaints Commissioner – submission to Productivity Commission Draft Report January 2020

## Introduction

The MHCC is pleased to contribute this submission to the Productivity Commission on their Draft Report on Mental Health. The MHCC is Australia’s only independent specialist mental health complaints body and has accumulated knowledge and experience about people’s experiences in and concerns about the Victorian mental health system from both the concerns raised by consumers, families and carers and the responses from services to these issues.

The MHCC has jurisdiction to deal with complaints made about Victorian public mental health service providers. Our submission therefore primarily focuses on issues relating to the provision of these services, based on what the MHCC has learned from the over 16,000<sup>1</sup> complaints made or reported to our office since 2014. However, it also draws on what we have learned through complaints about the interfaces between public mental health and other services. In addition, it draws on what we have learned through our broader education and engagement activities as well as feedback and input from our Advisory Council which comprises people with lived experience as consumers, families and carers and people with experience of working in mental health services.

This submission does not attempt to comprehensively respond to the draft recommendations, but provides comments in relation to selected recommendations.

The MHCC has also contributed to the joint submission made by the National, state and territory Mental Health Commissions concerning the role of National, state and territory Mental Health Commissions and accordingly this submission does not comment on these matters.

## Comments on selected draft recommendations

### Draft recommendation 5.2 – Assessment and referral practices in line with consumer treatment needs

The MHCC notes the recommendation that commissioning agencies ‘*should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care*’. In support of this recommendation, the MHCC notes the importance of ensuring that monitoring arrangements include clear, consistent and independent safeguarding and complaints mechanisms to assess whether people are receiving a level of care that meets their needs. It is important that there are clear and transparent ways for the views and experiences of consumers, families and carers to inform and guide any assessment of whether consumers are receiving an appropriate level of care. In the MHCC’s view, comparison of service use to expected service demand should not be the sole or even primary factor in assessing whether assessment and referral services are working effectively.

Please see also the MHCC’s response to draft recommendation 23.3 which focuses on the need for effective oversight, monitoring and safeguarding arrangements to be established in any rebuild of the mental health system.

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<sup>1</sup> This includes complaints made directly to the MHCC and local complaints reported by services for five years from 2014/15 to 2018/19.

## Draft recommendation 8.1 – Improve emergency mental health service experiences

The MHCC supports the recommendation to improve the experiences of emergency departments for people experiencing mental ill-health and notes the critical need for culture, as well as physical environment, to be addressed.

Since our first year of operation, complaints to the MHCC have raised consistent themes about the experiences of mental health consumers in emergency departments, including concerns about the nature of responses, the negative impacts of the environment, wait times, use of restrictive practices and the often highly traumatic nature of people's experiences. In complaints to the MHCC, consumers commonly speak about their fear and active avoidance of emergency departments.

The environment of the emergency department can be part of the cause of the distress experienced by people seeking mental health assistance, because of issues including:

- lack of privacy
- an unsuitable built environment including that partitioned beds are generally not needed, appropriate or conducive to recovery for people seeking mental health assistance
- the sensory stimulation of the generally busy environment of an emergency department making it difficult for people to rest or relax.

The lack of specific mental health expertise of emergency department staff, and challenges in many services with the interface between emergency department and mental health staff, are further concerns for people seeking urgent mental health assistance.

It is clear from the MHCC's work with consumers, families, carers and services that people experiencing mental health issues and mental illness also experience significant stigma when accessing emergency care, which should be more accurately described and understood as discrimination. This is a cultural issue in health and mental health services that is equally, if not more important, to address as the physical/built environment in order to meaningfully improve people's experiences and sense of safety.

The pervasive nature of discriminatory attitudes towards people experiencing mental health challenges and mental illness, can be seen in the rejection people can experience when presenting to emergency departments in distress, in the lack of compassion people can experience and in the use of stigmatising language that is commonly found in clinical records. Given that people accessing mental health treatment are likely to have a background of previous trauma, experiences of rejection by services and a lack of compassion can have a profound effect not only on their mental health journey but on their lives. Experiencing a lack of compassion or support at emergency department can lead and has led to people leaving the emergency department and experiencing serious adverse outcomes. It is not uncommon for people who have experienced a lack of compassion to tell the MHCC that they will never voluntarily seek mental health services again. In many cases people have a window of opportunity of willingness to seek assistance from services which is time sensitive and dependent on empathic and supportive responses from staff.

Examples of complaints to the MHCC about people's experiences in emergency departments include:

- people's concerns that they have been refused assistance from emergency departments or an admission to a mental health service because of a diagnosis of Borderline Personality Disorder or a substance use problem.
- experiences of unacceptably long waiting times in emergency departments when seeking mental health treatment including unacceptably long waits for an inpatient bed or waiting for compulsory mental health assessment
- the use of restraints for periods including overnight whilst waiting for a medical review and/or an inpatient bed.

These experiences can also be seen as discriminatory in terms of the lack of urgency demonstrated in response to people's mental health presentations and to the deprivation of people's liberty in these environments.

The MHCC supports the development of alternatives to presentation at an emergency department for people seeking mental health assistance, which could include alternatives based in the community that are inclusive, trauma informed and culturally safe. The MHCC notes the implementation of specialist mental health hubs in six emergency departments across Victoria, which may assist in addressing both physical and cultural issues experienced by people seeking urgent mental health care and treatment; however it is too early to assess whether these services will be effective in improving people's experiences.

## Draft recommendation 11.1 – The national mental health workforce strategy

Themes from complaints to the MHCC point to the importance of the mental health workforce being supported and enabled to work in ways that are person-centred and support individual recovery. To achieve these aims, we suggest that the new National Mental Health Workforce Strategy considers:

- the need to attract a workforce that has the appropriate skills, attitudes and capabilities required to provide person-centred, trauma-informed, recovery-oriented treatment and care, that supports people experiencing mental health issues and mental illness to exercise agency and choice in their treatment. This includes dedicated strategies to support the role and development of the peer workforce. The MHCC suggests that modelling should be undertaken following input from consumers, carers, and services about a desirable future workforce, rather than under a business-as-usual scenario – to best meet the expressed needs of people who seek to access mental health support and treatment, the future profile of the mental health workforce may be quite different from the profile that exists today..
- the need to employ the lived experience workforce to a scale that achieves a critical mass to sustain and support this workforce and build on existing peer led and delivered initiatives
- the need to attract a workforce that can ensure support is available to people who most need specialist care and treatment. We note the impact of high throughput in mental health services on the length and nature of care and treatment that people may receive.
- the need to ensure that the workforce has an appropriate mix and diversity to provide the kinds of care and treatment that people with mental illness find helpful in helping them in their recovery, noting in particular that people often express a wish for talking therapies, peer support, skills-based therapies or other interventions that could be used alongside or as an alternative to the primarily medication-based treatment options available through public clinical mental health services.
- whether the skills and capabilities of the existing mental health workforce are being used to the greatest extent possible, as noted in the interim report particularly regarding psychologists. The MHCC agrees that case management models of care often used in tertiary mental health services may mean that staff with specialised skills, for example in providing psychological intervention, may not have the opportunity to use these skills to the greatest extent possible.
- whether the health and mental health workforce needs additional support to develop the skills and capabilities required to provide person-centred, trauma-informed, recovery-oriented treatment and care. The MHCC's observations of the first five years of the operation of the Act are that the intended shift to person-centred, rights-based and recovery-oriented practices, along with the expected cultural changes in public mental health services, has not yet been realised.

- the need to address the impact of high demands on services on the capacity of staff to work in these ways (acknowledging that staff most often wish to develop these skills or dedicate time to working in these ways, but that service pressures impact their ability to do so)
- the likelihood that providing support and time for staff to work in ways that are person-centred, trauma-informed, and recovery-oriented will improve attraction and retention of the desirable workforce.

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

### Draft recommendation 11.4 – Strengthen the peer workforce

The MHCC strongly supports the recommendation to strengthen the peer workforce, to increase the availability of peer support to people experiencing mental health challenges. There are significant opportunities to expand the role of the lived experience workforce and increase people's access to peer support, across the mental health service system.

As the draft recommendations recognise, the lived experience workforce must have access to the kinds of structures and supports available to other workforces, including discipline-specific supervision, accountabilities and professional development. We suggest that these recommendations are strengthened to clarify that the lived experience workforce is the primary stakeholder in considerations of how to better support the lived experience workforce, as well as consumers, carers and families, and services.

We note the limitations of an implementation/expansion approach that is focused solely on educating other health professionals about the value of peer workers, which is unlikely to lead to behavioural and cultural change in how this workforce is understood and valued. We note the development in Victorian of the Victorian Mental Health Interdisciplinary Leadership Network (VMHILN). The VMHILN is a community of practice that unites existing and emerging leaders from Victorian area mental health services from lived experience workforce, nursing, allied health and medical staff. The Network focuses on actively leading change for recovery in local mental health services and broader policy reform, to improve the experiences of people who use services and those who work within them (see <https://www.vmhiln.org.au/>).

This kind of approach supports people in lived experience roles to use existing skills, build new skills and build their networks and connections with staff across disciplines within their service as well as across the state. It also supports staff from other disciplines to experience the value of lived experience perspectives in practice. Having experience of working directly with the lived experience workforce can support staff from other disciplines to incorporate working with lived experience staff in their practice, to more effectively support the people they work with. It can also support staff from other disciplines to become strong advocates for the role and value of the lived experience workforce, further increasing the reach and influence of this workforce. Considering a similar model or other way to embed lived experience leadership and expertise in services may be a more effective approach than educational programs, which evidence suggests are largely ineffective in changing entrenched attitudes and behaviours

The MHCC also supports the recognition of the significant expertise of lived experience workforce in considering how lived experience expertise could be recognised as prior learning from some health qualifications, provided care is taken in implementation to value lived experience expertise in its own right and not as a lesser stepping stone or pathway to other health qualifications.

### **Draft recommendation 10.3 – Single care plans for some consumers**

The MHCC supports this recommendation. The MHCC has considered a number of complaints where the inadequacy of shared care arrangements with general practitioners (GP) has been a key factor in a significant adverse event for the consumer.

### **Draft recommendation 10.4 – Care coordination services**

The MHCC supports this recommendation. Several complaints to the MHCC have highlighted the barriers to appropriate treatment and care for consumers with multiple and complex needs requiring collaboration by multiple agencies, especially for high risk consumers. The need for this is highlighted by a complaint from a consumer with a dual disability and complex needs who experienced lengthy periods of seclusion in a mental health service, and when all services involved in his treatment and care agreed the facility in which he was detained was unsuitable for him. Although he was entitled to an NDIS funded package the MHCC identified that a key barrier to his discharge from the facility was that there was no agency with overall responsibility for co-ordination, escalation and oversight of his care planning. As per our comments elsewhere in this submission, there must be a clear monitoring, oversight and safeguarding framework in place for any new commissioning arrangements.

### **Draft recommendation 12.2 – Guarantee continuity of psychosocial supports**

The MHCC supports this recommendation. Over 2018-19, the MHCC dealt with increasing numbers of enquiries and complaints relating to NDIS funded supports and decision making in 2018-19 in the NDIS transition period and identified a range of issues in relation to access and safeguards. This experience has highlighted the importance of early and considered planning of how safeguarding functions would operate in any proposed change to commissioning arrangements for mental health services. As recognised by this recommendation, many people with psycho-social disabilities have experienced difficulty to access appropriate supports in the transition to the NDIS and this has led to risks of disengagement with services, comprising people's recovery.

### **Draft recommendation 13.3 – Family-focused and carer-inclusive practice**

Implementation of the Carer Experience Survey and reporting of the outcomes of this survey will provide valuable insights into how families and carers experience their interactions with services. To maximise the usefulness of this data, it should be reviewed and analysed in conjunction with Your Experience of Service (YES) survey and other data including complaints data.

We note that while surveys are useful in providing high level information about carers' experiences and highlighting broad areas for service improvement, consideration should also be given the development of performance measures for family/carer involvement. Establishing and monitoring clear KPIs for the inclusion of families and carers (including young carers) in a person's care and treatment, and ensuring feedback is sought from individuals and families about the helpfulness of the range of approaches that may be taken within individual services, is more likely to provide services with practical and detailed information that can inform service improvement, particularly when considered alongside local complaints and feedback data.

As an overarching comment, it is important that the recommendations recognise the variety of ways that people see family, carers and support people. For example, many people including Aboriginal and Torres Strait Islander people and people from culturally diverse backgrounds may have a broad conception of family which should be recognised in the



supports offered and available. Family may include biological relatives, partners, ex-partners, people in co-habitation, adult and minor children, parents, siblings, friends, carers, community and others who play a significant role in the person's life. Family should be defined broadly to include the people who have a significant role in a person's life, and supports should be made available accordingly.

In the MHCC's broader engagement activities, it has been noted that mental health services vary in how well they ensure that children, young people and other dependents of persons receiving mental health services have their needs wellbeing and safety recognised and protected<sup>2</sup>. The MHCC supports the intent of the draft recommendation to better support services to implement family-inclusive practice, however we note the existence, recognised in the draft report, of the Families where a Parent has a Mental Illness (FaPMI) in Victoria, which embeds workers with a portfolio for embedding family inclusive practice in all adult mental health services. This program should be considered and built on in considering expansion to other jurisdictions.

## Draft recommendation 15.2 – Support people to find and maintain housing

The MHCC supports this recommendation. We note the significant impact of safe and secure housing on people's mental health and wellbeing. In implementing this recommendation, we suggest that the definition of homelessness be consistent with the definition used by the Australian Bureau of Statistics (defining homelessness as having a lack of one or more of a sense of security, stability, privacy, safety and the ability to control living space,<sup>3</sup> noting that complaints to our office and themes raised in our broader education and engagement work suggest that many people are discharged from hospitals to environments that feel or are unsafe and that negatively impact their recovery. We recognise the significant demand for acute mental health beds in Victoria, as well as shortages of safe and secure housing that impact mental health services' ability to support people to access safe and appropriate accommodation on discharge from hospital.

The MHCC has also received many complaints relating to inappropriate discharge, some of which were made by family and carers and point to the need to ensure that discharge planning is inclusive of families, carers and other support people. Some of the themes in these complaints include concerns:

- discharge from a service or refusal of service on the basis that a person's primary issue related to substance use, without follow up to support the person to access services to support them with substance use issues
- about discharge of family members from inpatient units while they were still unwell, particularly in the context of repeated admissions where families and carers felt that a longer admission would promote a better outcome
- from families or carers for their safety or that of others, if the consumer were to be discharged early
- that consumers were discharged into unsuitable accommodation or unsafe situations (including boarding houses or motels), and without adequate support or follow-up provided
- that consumers were discharged to the family home without prior discussion with the family, including in instances where family members were concerned for their own safety or ability to provide adequate care and support to their family member for reasons including being overseas, interstate or otherwise absent from the family home

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<sup>2</sup> As required by s 11(1)(j) *Mental Health Act 2014* (Vic)

<sup>3</sup> <https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4922.0main+features32012> accessed 23 January 2020

- unsafe or premature discharge by mental health staff in emergency departments, where consumers were deemed by staff not to be at risk to themselves or others and thus not requiring admission, despite their unwell state. Unsafe or premature discharge from emergency departments includes complaints where alcohol or drug affected consumers have been discharged from an emergency department in the middle of the night, without a safe way to get home and without the service making an effort to contact a family member or carer.

### **Draft finding 16.1 – Prevention and early intervention to reduce contact with the criminal justice system**

The MHCC notes that a number of models that use a collaborative approach between mental health, police and ambulance services kind exist in Victoria however are not universally available. Complaints to the MHCC highlight the trauma and humiliation people can experience when being apprehended by police and transported to hospital. We welcome the expansion of approaches that can improve these experiences to ensure that responses to people experiencing a mental health crisis:

- are trauma-informed
- enable first responders to have access to important information about the person including any views and preferences about treatment that the person may have expressed to their treating team or in an advance statement. This may also help to ensure that responses to people experiencing a crisis in the community are the least restrictive possible.
- are sensitive and responsive to the needs of families and carers including children or other dependents,

The MHCC also strongly supports models that would improve real-time communication between mental health services and Victoria Police. We note that poor communication, particularly about the urgency of a requested police response, can have and has had serious consequences including where an earlier response may have prevented serious self-harm.

### **Draft recommendation 16.2 – Mental healthcare standards in correctional facilities**

The MHCC supports this recommendation. The MHCC has jurisdiction over services provided by designated mental health services in Victoria, which represents only some of the mental health services available in prisons. However, the MHCC receives many complaints from prisoners (with calls from prisoners comprising eight percent of all phone calls to our office in 2018-19), many of which relate to their ability to access appropriate mental health support or about delay in receiving mental health treatment.

We note the need for resourcing to be considered to support services providing mental health services in prisons to meet improved standards, acknowledging the existing over-representation of people experiencing mental health challenges within the prison system and the high demand already experiencing by services.

### **Draft recommendation 16.7 – Non-legal individual advocacy services**

The MHCC supports this recommendation. The MHCC works closely with Independent Mental Health Advocacy (imha) in Victoria, including receiving referrals from them from people who wish to make a complaint, and supporting people receiving compulsory treatment to access imha information and assistance to support their ongoing discussions with their treating team.

One of the most consistently common themes in complaints to the MHCC is from consumers, families, carers and nominated persons stating that their views about treatment, and consumers' preferences, have not been adequately considered by the service. . Common examples include:

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

Provision of non-legal advocacy can support people to have their views and preferences about their compulsory treatment included in the treatment planning process and could significantly improve people's experiences of mental health services. The MHCC notes that ultimately, it should be expected that mental health services will work in ways where supported decision making is fully implemented and the level or nature of advocacy required may change over time. However, this requires long-term capacity building and cultural change within services and non-legal advocacy is a useful and effective part of effecting this change.

### Draft recommendation 20.1 – National stigma reduction strategy

The MHCC supports this recommendation, noting that State and territory Mental Health Commissions currently have varying responsibility for addressing stigma within their jurisdictions. We recommend that the NMHC work in partnership with existing state and territory Mental Health Commissions in fulfilling this recommendation. We strongly support the recommendation that a stigma reduction strategy should rely on the leadership and direction of people with lived experience.

As noted above in relation to improving peoples' experiences of emergency departments and as acknowledged in draft recommendation 20.1, people experiencing mental health challenges face stigma within health and mental health settings as much as, or perhaps even more strongly than they do within the broader community. The MHCC strongly supports the recommendation to address stigma that exists within mental health and broader health services, particularly within emergency departments where many people report their strongest experiences of being stigmatised or discriminated against because of their mental health challenges. In addition to the examples noted above in relation to emergency departments, other examples of people experiencing stigma, discrimination or insensitive care within mental health services include:

- people not receiving holistic or person-centred treatment as a result of having particular diagnoses (particularly borderline personality disorder)
- medicalisation/problematisation of emotional distress rather than acknowledgment of distress as a response to trauma
- staff becoming desensitised to people's experiences and using shaming, minimising or otherwise negative language to describe people's experiences or presentations, or labelling people by their diagnosis
- staff becoming desensitised to the gravity and distressing nature of interventions that are used within mental health services including the use of seclusion, restraint and compulsory treatment, and the impact of these interventions on consumers and their families and carers.

We also note that people may internalise society's messaging about mental health which can prevent them from seeking or accepting help and cause people to experience shame, hopelessness, isolation and exclusion, distress and blame which can significantly impact their recovery journey. This can be compounded by the experiences people may have within health and mental health services and highlights the need for the elimination of stigma within health services and the need for compassionate, rights-based care and treatment.

While addressing experiences within health services will be supportive in reducing self-stigma, we also recommend that a stigma reduction strategy consider ways to support people experiencing mental health challenges to understand and exercise their rights particularly in relation to accessing and receiving mental health care.



## Draft recommendation 22.3 – Enhancing consumer and carer participation

The MHCC supports this recommendation. However, we note that the role and value of codesign, codelivery and co-evaluation of services could be greatly strengthened throughout the draft recommendations. Greater embedding of coproduction within the mental health system and support for lived experience leadership across all aspects of the mental health system are critical to ensure that the services provided are the services people need and want to improve people's recovery, wellbeing and participation in the broader community. These may be different and/or additional to the kinds of services that are currently provided.

The views and experiences of consumers, families and carers must drive decisions about the kinds of services that are provided to prevent crises, to respond early when a crisis occurs and to best support recovery. To build an effective mental health system that supports and does not harm or traumatise people experiencing mental ill-health and their families and carers, mental health services must be:

- designed, developed and delivered together with people with lived experience and that of meet the self-identified needs of local communities (for example, models that work well in metropolitan areas may not be suited to rural or regional communities and vice versa)
- evaluated and monitored in conjunction with people with lived experience, including via the development of improved safety and quality indicators for mental health services that identify measures that will ensure adequate oversight of the issues that consumers, families and carers see as most important to providing safe, quality care and treatment. These issues may be different to the kinds of issues that are currently measured and may include, for example:
  - public reporting of alleged physical or sexual assaults occurring in mental health services, as well as
  - developing measures about the extent to which people feel their views were respected and supported during their treatment
  - developing measures about the extent to which mental health services seek to engage and work with families and carers.

The MHCC suggests this recommendation could be framed more broadly to promote consumer, carer and family leadership across all levels of the mental health system and to seek for lived experience to drive planning and design decisions from the beginning of these processes. The Victorian Mental Illness Awareness Council (VMIAC)'s recent '[Declaration of something wonderful](#)' was created by people across Victoria with lived experience of emotional distress, trauma, neurodiversity and mental health challenges. A strong theme of this Declaration is the wish of many people for greater choice to different kinds of services and supports, including many that are not available or available in very limited ways within current service models.

## Draft recommendation 23.3 – Structural reform is necessary

The MHCC notes the need for a clear framework to be established for monitoring, oversight and safeguarding for any proposed new commissioning arrangements. While regional control and responsibility for allocation of funding may have a number of positive impacts, particularly if consumers, families and carers have a role in informing and making decisions about funding allocations, care needs to be taken to ensure that monitoring, oversight and safeguarding functions are consistent and equally available to all people. The volume and gravity of complaints to the MHCC, particularly those involving breaches of the *Mental Health Act 2014* (Vic), rights violations and avoidable harms, demonstrate the value of and need for independent oversight and accessible complaints mechanisms.

The MHCC has observed the importance of responding to people's individual needs and concerns and the difference that a positive resolution of a complaint can make to a person's wellbeing, recovery and future engagement with services. In some cases, the resolution of a complaint can be a lifeline to a person who may not have otherwise sought further help from mental health services. As Australia's only independent, specialist mental health complaints body, the MHCC deals with significantly more mental health complaints than any other

Australian jurisdiction. This demonstrates the value of having an independent, supportive body that can respond to the specific needs of people experiencing mental health challenges to better support people to speak up about their experiences and contribute to service and system improvement.

It is also critical that the information learned from the performance of monitoring, oversight and safeguarding functions can be shared with the entire system to promote improvement across whole jurisdictions.

In line with comments elsewhere in this submission and in order to best provide the kinds of services that would best meet the needs of people experiencing mental health challenges, their families and carers, regional commissioning systems and processes should be designed so that consumers, families and carers have direct and meaningful impact on the nature of services that are commissioned.

### **Draft recommendation 25.2 – Routine national surveys of mental health**

The MHCC broadly supports this recommendation, which would assist in better understanding the mental health and wellbeing of Australians. We support an approach that uses the social determinants of health as a guiding principle, to ensure that the definition of 'service use' by people with mental illness encompasses the full range of services that are available in the community as well as broader participation in and connection to the community.

### **Draft recommendation 25.4 – Strengthened monitoring and reporting**

The MHCC supports this recommendation, which is consistent with approaches being taken by the Department of Health and Human Services in Victoria to develop a performance and accountability framework that focuses on outcomes across a range of domains that measure overall wellbeing and connectedness with the community. The MHCC supports the use of the Contributing Life Framework as a basis for deriving outcome areas.

### **Draft finding 25.1 – Monitoring and reporting at the service provider level**

The MHCC strongly supports increased monitoring and reporting at a regional and service provider level. We note the importance and value of including measures that represent the experiences of consumers and carers, including complaints data as well as Your Experience of Service (YES) and Carer Experience of Service (CES) survey measures where there is sufficient data for this to be meaningful (noting, for example, that some services in rural and regional areas are very small and this may affect whether and how survey and complaints data could be published). Transparent reporting is an important step to help services to assess where they are doing well compared to other like services and where there are areas for improvement, and take action accordingly to improve service quality.

Increasing the scope of data reporting to include experience measures including complaints data also goes some way to addressing existing data limitations, and increases the breadth and depth of information available to consumers and carers about service quality.

For questions about this submission or to seek further information please contact Ms Rachel Vague, Manager, Strategy and Quality