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Australian Commission on Safety and Quality in Health Care

8th May 2023
Re: Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard Public Consultation

We wish to focus our submission on consultation question 1: 'Does the quality statement adequately describe the quality of care that should be provided?', and specifically provide comment on Quality Statements 1 (Person- and family-centred care) and 6 (Appropriate reasons for prescribing 2 psychotropic medicine).

Quality Statement 1: A person receives healthcare that is driven by their individual preferences, needs values, and upholds their personal dignity, and human and legal rights. The person and their family are supported to be active participants and make informed choices about their care.

We note that the terms shared decision making and supported decision making are used interchangeably in the document. While many of the principles of supported decision making are thoroughly conveyed in Quality Statement 1, we note that the term 'shared decision making' is used in Quality Statement 1, page 21, line, and is also repeated throughout the document. This may cause confusion for consumers and clinicians in using this resource, as these are two separate practices with different goals and purposes. In 2022, CoMHWA was commissioned by the Mental Health Commission W.A. to write a literature review on supported decision making. In the review we distinguish between shared and supported decision making, noting that supported decision making is best practice and is being utilised in settings both nationally and internationally. While shared decision making recognises that both clinician and consumer bring unique expertise and must work together to agree on a decision, it is difficult to state with certainty whether this relationship can ever be truly 'equal', given the power granted to psychiatrists and other clinicians to make decisions that override those made by the consumer, especially if they are deemed to be making the 'wrong' decision. The United Nations Convention for the Rights of People with Disabilities (UN CRPD) emphasises the legal capacity of all individuals to make decisions, and argues that equity in this field requires that people have access to the support they need in order to make decisions. Supported decision-making focuses not on the outcome of decision but that the person most deeply involved in making the decision is the person who will be affected most by the impact of the choice.

We advocate for supported decision making to be used exclusively as the framework that ensures the voice of consumers are heard.

Quality Statement 6: Psychotropic medicine is considered in response to behaviours of concern only when there is a significant risk of harm to the person or others, or the person is in severe distress and non-drug strategies are not effective. Psychotropic medicine is also appropriate for treating a diagnosed medical condition, or as a time-limited trial when a diagnosis cannot be made with certainty, but is likely following a documented clinical assessment. The reason for use is documented in the person's healthcare record at the time of prescribing.

The *Psychotropic Medicines in Cognitive Disability or Impairment Clinical Care Standard* consultation paper states that: '*The Royal Commission highlighted serious safety issues relating to the use of psychotropic medicines in these people. They identified that the misuse and overuse of psychotropic medicines for their sedative effects to influence a person's behaviour – rather than for treating a mental health or physical condition*'. CoMHWA is pleased that the consultation document acknowledges this and is working to prevent this in consumers. However, there are some points

regarding the use of psychotropic medicine for those with cognitive disability or impairment that we would like to raise below.

CoMWHA operates from a consumer-focussed, human rights framework and represents our members to address systemic issues in the mental health system. Many of our members have lived experience with restrictive practices, and it is our position that we recognise restrictive practice as a failure of care that should be eliminated in every instance in favour of therapeutic, person-centred and holistic approaches to de-escalation and safeguarding. We note that the *Mental Health Act 2014* (*MHA*) in W.A., recognizes and regulates two forms of restrictive practice: seclusion and restraint.

- Seclusion: 'the confinement of a person who is being provided with treatment or care at an authorised hospital by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave[1].'
- Physical restraint: 'the restraint of a person by the application of bodily force to the person's body to restrict the person's movement[2]'.
- Mechanical restraint: 'the restraint of a person by the application of a device (for example, a belt, harness, manacle, sheet or strap) to a person's body to restrict the person's movement[3]'.

Although chemical restraint is not explicitly stated in the *MHA*, the Office of the Chief Psychiatrist is responsible for overseeing and regulating restrictive practice, as set out by the Act, in authorised mental health settings in the State. This means that instances of restrictive practices not defined in the *MHA* (such as chemical or psychological/emotional restraint), or which occur outside of authorised mental health settings (such as emergency departments, in transport or in non-authorised hospital wards) are not recorded or accounted for by an independent body.

Further, from a human rights perspective, the United Nations' Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment states that '*It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions*[4].'

Psychotropic medicine from CoMHWA's perspective is another form of restraint that is used on consumers to sedate them rather than for the purpose of treatment on their recovery journey. Although these clinical care standards are working towards the appropriate use of psychotropics, we remain concerned that there will be instances that this will not be implemented which will have negative impacts on consumers. The dehumanising effect of restrictive practices on consumers is a major concern for many CoMHWA members, and the lived experience of members consulted for feedback highlighted how these practices led to fear, anxiety and despair for those that are subjected to them. Members noted that instances where these practices were used deeply impacted those restrained, traumatising both the subject of restrictive practices, and other consumers witnessing such practices.

We would lastly like to recommend that the term 'harm' be fully explained with examples for clarity around how these guidelines are to be implemented. Including this term in the Glossary would help in ensuring readers understand how the term is deployed in the document. In Quality Statement 6, page 38, lines 28-29, the document states: 'A medicine should only be offered or recommended if it is more likely to help someone than cause them harm.' We argue that definitions of harm in this instance should account for iatragenic harm, where consumers experience lasting negative mental or emotional trauma sustained while receiving health services.

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[1] *Mental Health Act 2014* (WA), s. 212
[2] *Mental Health Act 2014* (WA), s. 227
[3] *Mental Health Act 2014* (WA), s.227
[4] Report of the Special Rapporteur on torture and other cruel inhuman or degrading treatment or punishment. 2013, 14. A/HRC/22/53 (United Nations General Assembly, February 1).