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Key messages

- SDM acknowledges every person has the right and capacity to make informed choices and autonomous decisions. Where a person's capacity appears to be temporarily compromised, SDM provides practical means to enhance a person's capacity to meaningfully engage in decision-making.
- SDM is intended to facilitate greater consumer involvement in making key clinical decisions and uphold respect for consumers' rights and autonomy.
- The principles of SDM should inform every psychiatric consultation.
- Psychiatrists need to familiarise themselves with both the principles and practice of SDM and ensure that this becomes a core competency during psychiatric training.
- The principles are consistent with the UN CRPD and provide greater respect for rights and autonomy.
- Utilising the direct lived experience of consumers helps enable SDM and empowers people by directly strengthening their dignity and autonomy.

Purpose

The Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP Victorian Branch) has produced this position paper to educate and inform its members, consumers and their families, and other clinicians about the principles of supported decision-making (SDM). This paper aims to influence the increased uptake and future embedding of SDM in clinical practice, by Victorian psychiatrists, and in Victorian Mental Health Services. It is further hoped that this will influence and inform the development of a future RANZCP bi-national position on SDM within Australia and New Zealand.

Developing this paper and adopting SDM underscores a commitment to Australia's signatory status of the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) to promote, protect and ensure the full and equal enjoyment of the human rights of all persons with a disability.

This paper was developed by the RANZCP Victorian Branch Enabling Supported Decision-Making Subcommittee (comprising equal numbers of consumers and clinicians) utilising a co-production methodology. Co-producing this paper highlights a commitment by the RANZCP Victorian Branch to utilising a methodology which mirrors the principles of SDM. This includes an equal partnership approach to the development and review of policy and services as an ideal standard for practice.

Whilst this paper has been developed specifically within the framework of the *Mental Health Act 2014* (Vic), we acknowledge that the Act itself contains some coercive elements (compulsory treatment, in the absence of informed consent, being coercive by its nature). SDM principles have applicability across all Australian and New Zealand jurisdictions. The RANZCP Victorian Branch encourages the consistent application of these principles as part of routine clinical practice by all

mental health clinicians in the hope that this will lead to less coercive practice and involuntary treatment. SDM is an evolving process and the RANZCP Victorian Branch is committed to evolving with it.

The paper promotes SDM and the presumption of capacity as a cornerstone of psychiatric practice. In areas of decision-making where capacity is diminished, the principles of SDM are intended to uphold the rights of people in treatment to participate in decisions related to their treatment to the maximum extent possible. This paper also works to promote and facilitate collaborative and empowering interactions between mental health clinicians, consumers and the community to provide better outcomes for people with mental ill health. Embedding SDM into every step of the recovery journey will reinvigorate fundamental discussions about how we work together towards improved health and wellbeing.

Background

The *National framework for recovery-oriented mental health services* (Australian Health Ministers Advisory Council, 2013) highlights the goal of maximising the ability of people with mental ill health to engage in all areas of life. This includes a clear expectation that consumers should actively engage in treatment decisions relating to their illness, whilst recognising that at times, the expression of illness may place constraints around their ability to do so. A SDM framework aims to bolster elements of capacity and is thus an important element of the recovery paradigm.

The need for mental health clinicians to incorporate SDM into routine practice is an important part of ensuring that practice aligns with local mental health legislation, and with the UN CRPD.

One of the lenses through which psychiatry can be viewed is that of an 'agent of social control.' In the RANZCP Position Statement 84: [Acknowledging and learning from past mental health practices](#) (2016), the profession has acknowledged past abuses and the learning it has acquired from past mental health practices. It also recognises the lived experience of many mental health consumers is that admission and treatments retain elements of coercion (Hotzy and Jaeger, 2016).

Letting go of unhelpful attitudes to mental ill health, and focusing on learning from consumers' experience reduces vulnerability, builds rapport and furthers the work already being done to promote and enhance recovery.

SDM can be viewed as a logical extension of the consumer rights movements that began in the 1960s and contributed to deinstitutionalisation. Subsequently, we have seen an increased cultural emphasis on freedom of choice and respect for individual rights. For example, this movement has led to inclusion of consumers and carers in service design and delivery.

Definitions

Co-Production

Co-Production involves consumers and clinicians working in equal partnership to design, deliver and evaluate agreed objectives. Ideally it also involves carers, families, and other support networks.

The three guiding principles of co-production by Grey and Roper (2015) that directed the work and objectives of this paper are:

- **Partnership:** Consumers are partners from the outset.
- **Power:** Power differentials are acknowledged, explored and addressed.
- **Leadership and capacity:** Consumer leadership and capacity are grown.

(For further information on co-production, see Roper et al., 2018).

Supported Decision-Making (SDM)

SDM is a means of enabling consumers to understand choices in relation to their treatment. Consumers receive support in their efforts to make decisions for themselves.

Supported decision-making is NOT:

- shared decision-making, which is where the consumer participates in the decision-making process but the final decision is not made by the consumer
- substitute decision-making, which is where a third person makes the decision for the consumer.

SDM in any health setting is more than having family, professional or community advocates present at key treatment decision-making meetings or tribunals. It is a collaborative approach to support an individual in their decision-making.

Many consumers already use SDM processes to enhance decision-making across other life domains, for example, having informal discussions with someone who has been through similar experiences or has needed to make a similar decision.

Dignity of Risk

As defined by the Victorian Government Framework for Recovery-oriented Practice, dignity of risk means a version of positive risk-taking that 'involves optimising informed choice and consumer-led decision-making, even where this involves a degree of perceived risk' (Victorian Department of Health and Human Services, 2011).

Discussion

A number of complex issues feed into SDM, including that:

- many consumers and families recognise that it can be hard to communicate when ill, and a trusted advocate (e.g. a nominated person, family member, carer) may be helpful in this process
- issues of risk can be paramount including the dignity of risk
- sometimes it can take months or years to appreciate the long-term consequences of complex decisions
- past decisions, made in good faith may turn out to have unforeseen consequences (and we are all learning together).

Capacity and Informed Consent

Capacity as a concept is fluid and decision specific and must be considered in relation to its circumstance and be based upon the tenants of the UN CRPD, Article 12 of the CRPD (which reinforces the assumption of legal capacity). Whilst legal capacity is a distinct concept from mental capacity, the UN CRPD commented that the CRPD 'does not permit perceived or actual deficits in mental capacity to be used as justification for denying legal capacity'.

For the purposes of this paper, when discussing capacity we refer to the capacity to give informed consent, as defined in the Victorian Mental Health Act 2014. Capacity is the ability to give [informed consent](#) to a particular treatment at a particular time.

Having the capacity to make a decision is a core requirement of the informed decision-making process. Seeking a person's informed consent respects their autonomy and their human rights.

As defined in the Victorian Mental Health Act 2014, it should not be assumed that a person does not have the capacity to give informed consent based only on their age, appearance, condition or an aspect of their behavior. By providing practical means to enhance and support that person's

understanding of information and ability to engage in decision-making, SDM bolsters their capacity to determine and communicate a choice. Such practical means might include the use of communication aids (e.g. listing options clearly and simply on a piece of paper with the person; using flip cards with information about treatments), advance statements, informal supporters such as a trusted friend or family member, and the use of nominated persons/advocates.

Core aspects of informed consent in the context of SDM include:

- The person is provided with all necessary information to support them to make a particular decision, including the potential risks and benefits of the possible choices.
- The person has the opportunity to make a decision based on the information provided to them. If aspects of their capacity appear to be compromised, then supportive and active processes to bolster capacity are provided.
- The person's decision is voluntary and is expressed without that person being subject to coercion, manipulation or the perception of threat by any other person or institution.
- In situations where capacity may appear reduced from other times, having an advance statement in place may form part of an informed consent process.

Core elements of 'capacity' in the context of SDM include:

- The person is able to understand the information provided to them.
 - Supports to enhance understanding might require that the consumer is provided with aids or prompts to enhance their understanding and working memory. This may be as simple as a list of various treatment options written collaboratively by both clinician and consumer (with adequate time for the consumer to consider the options).
- The person is able to weigh the risks and benefits, and appreciate the consequences of decisions they might make, relative to their experience, values and priorities.
 - For example, once the clinician and consumer have composed a list of treatment options together, the core risks and benefits of each are able to be discussed. A consumer may take into account their values and previous negative experiences of medications when making decisions about a treatment change. If a consumer has consistently rejected a specific treatment option, even at times when their mental state has been optimum, this needs to be respected as far possible, taking risk and the relevant mental health legislation, into account.
- The person is able to communicate their decision in the absence of coercion.
 - If SDM supports have been used throughout, a consumer's ability to communicate their decision should be enhanced. Providing a consumer with a copy of any notes or aids used during the consultation process may prompt recollection of the nature of the process utilised.

Underpinning the points above is the presumption that all people have the human right to autonomously make their own decisions and have the capacity to do so. It cannot be assumed that someone is unable to make a decision for themselves simply by virtue of having a particular diagnosis.

Capacity can certainly vary over time but it can be enhanced in any situation. SDM focuses on practical methods to enhance capacity.

The intent of SDM is not to merely shift risk and responsibility for decision-making and treatment outcomes from mental health clinicians and onto consumers, their families and carers. Instead, it places increased responsibility on clinicians to improve their way of practising in order to strengthen consumers' capacity to make decisions, whilst reducing practices viewed as coercive or manipulative.

Evidence

It is worth noting that basic human rights are a fundamental expectation, which underpin SDM, and are enshrined in the UN CRPD.

With regards to SDM as a means of upholding these rights, there are different forms of evidence from diverse fields and disciplines. We recognise the lived experiences of consumers, carers and mental health clinicians as an essential part of the evidence base and supported through SDM.

SDM is an area in which research is rapidly emerging. However, existing evidence has been reported in academic studies including:

- *A.C.T. Disability, Aged and Carer Advocacy Service (ADACAS) Report (2016)*
- *People making choices: the support needs and preferences of people with psychosocial disability (2014)*
- *Options for Supported Decision-Making to Enhance the Recovery of People Experiencing Severe Mental Health Problems (2017).*

Considerations for mental health practice

While risk assessment by its very nature is an inexact process, clinicians have expertise in the assessment of risk and the provision of treatment. Thus, there may be a perception that empowering consumers to be central in making decisions about their care might increase clinical risk and compromise treatment. Whilst this is a complex issue, the RANZCP Victorian Branch supports a balanced clinical approach that integrates and respects the dignity of risk alongside issues of safety for the individual and the community. This clinical approach should consider the right for those with capacity to make decisions that clinicians and those in a support role may not agree with.

SDM does not permit clinicians to do less, or to neglect consumers – it does require clinicians to improve interpersonal relationships, and to explore, review and respect consumer values.

Recommendations

The RANZCP Victorian Branch:

- Encourages the use of SDM principles by all Victorian psychiatrists across all practice settings.
- Will work with Victorian advocacy groups and other key stakeholders to identify opportunities to improve the understanding and implementation of SDM by mental health clinicians.
- Encourages the implementation and adoption of mechanisms for evaluating change in practice.
- Encourages psychiatrists, in their capacity as both leaders and members of multidisciplinary mental health teams, to promote the principles of SDM within their own services.
- Will ensure that future review of this paper maintains elements of the co-production processes used in its development.
- Encourages all psychiatrists and trainees to improve their education and training in the use of SDM principles to clearly identify differences between shared and supported decision-making either via the training package, online training module (both in-development) or other suitable training opportunities.
- Will promote resources and tools to support SDM as a core competency for psychiatric trainees in Australia and New Zealand.

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Relevant RANZCP publications:

- Royal Australian and New Zealand College of Psychiatrists (2018) [Code of Ethics](#).
- Royal Australian and New Zealand College of Psychiatrists (2017) Position Statement 92: [Mental health legislation and psychiatrists: putting the principles into practice](#).
- Royal Australian and New Zealand College of Psychiatrists (2016) Position Statement 85: [The contribution to practice made by psychiatrists who have a personal experience of mental illness](#).
- Royal Australian and New Zealand College of Psychiatrists (2014) Position Statement 62: [Consumer and carer engagement](#).
- Royal Australian and New Zealand College of Psychiatrists (2013) Position Statement 80: [Role of the psychiatrist](#).
- Royal Australian and New Zealand College of Psychiatrists (2012) Position Statement 76: [Supporting carers in the mental health system](#).
- Royal Australian and New Zealand College of Psychiatrists (2012) Position Statement 73: [Principles to underpin effective mental health service delivery to the Community](#).
- Royal Australian and New Zealand College of Psychiatrists (2002) Position Statement 47: [Psychiatrists as team members](#).

Disclaimer

This information is intended to provide general guidance to practitioners. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances, information or material that may have become subsequently available.

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