The Royal Australian & New Zealand College of Psychiatrists
Victorian Branch

6 April 2017

Prof Brian K Owler
Chair
Ministerial Advisory Panel

By email to: Assisteddying.frameworkresponses@dhhs.vic.gov.au

Dear Professor Owler

Re: Voluntary Assisted Dying Bill

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to respond to the Ministerial Advisory Panel's (the Panel) discussion paper on a Voluntary Assisted Dying Bill. The RANZCP believes that psychiatrists can play a crucial role in informing the debate about voluntary assisted dying by virtue of their expertise in physical and mental illness.

The RANZCP has more than 6000 members, including more than 4000 qualified psychiatrists, many of whom have specific interest and expertise relevant to the Inquiry. In developing this submission, the RANZCP worked closely with its expert members and representatives to ensure that the recommendations made reflect clinical excellence, community experience and insight.

In acknowledgement of the scope of the discussion paper, comments in this submission are limited to the requirements of a robust framework for voluntary assisted dying. Nothing in this submission should be taken as explicit or implied support of the legalisation of voluntary assisted dying by the RANZCP. However, a few comments will first be offered here regarding some of the potential impacts of a legalised framework for voluntary assisted dying that should be considered if the framework is implemented. Should the Panel wish, they may refer to the RANZCP's Position statement 67: Physician assisted suicide for general information about our position on physician/voluntary assisted dying.

The RANZCP notes growing evidence suggesting that Australia's oldest citizens are at increased risk of suicide and may therefore consider voluntary assisted dying. The RANZCP is concerned about the potential impact of the implementation of a voluntary assisted dying framework on older persons and considers that the implementation of a voluntary assisted dying framework should be complemented by suicide prevention programs which target older persons and stringent safeguards to ensure that older people considering suicide are not given access to voluntary assisted dying.

The RANZCP considers that the primary role of medical practitioners, including psychiatrists, in end-of-life care is to facilitate the provision of high-quality patient-centred care. However, without the adequate resourcing and accessibility of palliative care, the legalisation of voluntary assisted dying may present a perverse incentive for patients suffering enduring and unbearable suffering caused by a serious and incurable condition to choose to end their life,

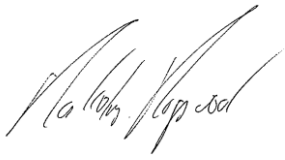
309 La Trobe Street, Melbourne VIC 3000 Australia
T +61 3 9640 0646 F +61 3 9642 5652
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

rather than have their pain alleviated. The implementation of a voluntary assisted dying framework should therefore consider the need for increased supports to the palliative care sector.

For detailed responses to the questions provided in the discussion paper, please see the attached submission which we hope will be of assistance.

If you would like to discuss any of the issues raised in the submission, please contact Rosie Forster, Senior Department Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours sincerely



Professor Malcolm Hopwood
President

Associate Professor Richard Newton
Chair, Victorian Branch

Ref: 0678o

The Royal Australian & New Zealand College of Psychiatrists

Voluntary Assisted Dying Bill

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promoting the role of psychiatrists as medical doctors and experts in mental health

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a bi-national college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 6000 members including more than 4000 qualified psychiatrists. Psychiatrists are prominent among clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey to recovery. The RANZCP is guided on policy issues by a range of expert committees made up of leading psychiatrists with relevant expertise, and consumer, carer and community representatives.

Introduction

Psychiatrists can play a crucial role in informing the debate about voluntary assisted dying by virtue of their expertise in physical and mental illness. The Victorian Branch of the RANZCP (VIC Branch) welcomes the opportunity to respond to the Ministerial Advisory Panel's (the Panel) discussion paper on a Voluntary Assisted Dying Bill.

In acknowledgement of the scope of the discussion paper, comments in this submission are limited to the requirements of a robust framework for voluntary assisted dying. Nothing in this submission should be taken as explicit or implied support of the legalisation of voluntary assisted dying by the RANZCP. Should the Panel wish, they may refer to the RANZCP's Position statement 67: Physician assisted suicide for general information about our position on physician/voluntary assisted dying.

The VIC Branch notes that Australia's oldest citizens, those aged 80 and above, are the age group most likely to die by suicide (ABS, 2012). This has led to a misconception that suicide in older people is largely driven by suffering associated with chronic, debilitating or terminal illness (McKay, 2014) whereas the aetiological factors of suicide are complex and multifactorial. A voluntary assisted dying framework must take into consideration the under-diagnosis and under-treatment of depression and suicidality in older people.

The VIC Branch is concerned that this misconception may lead individuals to erroneously conflate suicide with voluntary assisted dying. While the latter may be an understandable choice in the context of unbearable suffering, suicide is a tragic outcome for individuals who suffer from mental illness. Given the disastrous consequences for the individuals, families and communities of those who commit suicide, it is imperative that the implementation of voluntary assisted dying be accompanied by stringent safeguards to ensure that older people considering suicide are not given access to voluntary assisted dying, as well as an expansion of suicide prevention programs to target older persons.

Finally, the VIC Branch considers that the primary role of medical practitioners, including psychiatrists, in end-of-life care is to facilitate the provision of high-quality patient-centred care. Palliative care should strive to achieve the best quality of life during the final stages of patients' illnesses and allow patients to die with dignity. However, without the adequate resourcing and accessibility of palliative care, the legalisation of voluntary assisted dying may present a perverse incentive for patients suffering enduring and unbearable suffering caused by a serious and incurable condition to choose to end their life, rather than have their pain alleviated. The implementation of a voluntary assisted dying framework should therefore be accompanied by increased supports to the palliative care sector.

The person

Is the existing decision-making capacity test in legislation such as the *Medical Treatment Planning and Decisions Act 2016* sufficient?

The issue of capacity is a critical consideration on the debate on voluntary assisted dying. The VIC Branch supports the decision-making capacity test in the *Medical Treatment Planning and Decisions Act 2016* (the Act) especially the provisions for supported decision-making.

Ensuring that a person with mental illness has capacity to request voluntary assisted dying may pose significant challenges. The cognitive power required to have decision-making capacity exists along a continuum and no legislative instrument relating to the assessment of decision-making capacity would therefore be complete without recognition of this fact. We note especially that the unpredictability of mental illness means that a person's cognitive capacity can even experience significant fluctuations in short periods of time and can vary depending on the matter being addressed. The VIC Branch therefore supports the Act's acknowledgement that diminished capacity may be temporary but further suggests expanding this statement to include reference to environmental factors so as to ensure that assessments are made in suitable conditions.

In what circumstances should a psychiatric assessment be required? Are there any other specialist referrals that would be appropriate for assessing decision-making capacity?

The VIC Branch strongly supports a framework which mandates consideration of psychiatric assessment of patients whose decision-making capacity is in question. There would be significant practical barriers to psychiatrists carrying out mandated assessments of all patients seeking access to voluntary assisted dying in a timely way. This is of particular concern in a population that is defined by their limited life expectancy. However, when necessary, psychiatrist assessment may be vital in making determinations about capacity as psychiatrists have specific skills and expertise to assess decision-making capacity as well as to identify psychiatric illnesses and to assess suicidal ideation in patients, including the terminally ill. Assessment of capacity is a part of basic medical training and the RANZCP training program includes advanced competencies in capacity assessment. Furthermore, treatment for mental health issues can help to relieve the experience of physical pain, due to the interaction of biological and psychological systems.

The VIC Branch notes here that there is a need for increased support of non-psychiatrically trained doctors to recognise diminished capacity and refer patients for assessments in the context of voluntary assisted dying when compared with refusals of care. In situations where a patient has a terminal condition causing enduring and unbearable suffering, there is a risk that symptoms of mental ill health may be mistaken by a doctor not trained in psychiatry for an 'understandable' reaction to their condition. Furthermore, traumatic brain injury, addiction issues, dementia and delirium may all confound assessments of capacity and non-psychiatrically trained doctors 'are not well placed to recognise the presence of these conditions in the medically ill population' (Ryan, 2012).

To mitigate these risks, the VIC Branch suggests that training be provided to non-psychiatrically trained professionals by psychiatrists with relevant expertise, and that resources be developed covering:

- screening tools for mental disorders and neuropsychiatric conditions
- other risk factors to look out for, including vulnerable populations, such as older, isolated women, who may seek access to voluntary assisted dying more often

- guidance on the appropriate use of telehealth, noting its potential to increase access but also to compromise the integrity of assessments
- how to interact with families/carers, and what to do when a patient does not wish to involve their family.

The VIC Branch also notes that, due to the often rapidly changing manifestations of mental illness, proper assessments are best undertaken by clinicians with the benefit of extended interactions over a significant period of time with the individual in question. As such, the views of psychiatrists and/or other mental health professionals with established therapeutic relationships with individuals seeking voluntary assisted dying should be sought wherever possible.

Access and eligibility

Is greater specificity required to identify what constitutes a person being at the end of life and, if so, how should that specificity be worded?

The VIC Branch acknowledges the value of specialist medical expertise in making these determinations.

How should a 'serious and incurable condition' be defined?

The VIC Branch would support the definition of a 'serious and incurable condition' as one that is terminal. The VIC Branch also strongly supports the framework excluding suffering as a result of psychiatric illness as a basis for accessing voluntary assisted dying.

Making a request

Should there be a prescribed time period that must pass between the first and final request and, if so, what period?

The VIC Branch believes that the time period between the first and final request should be as long as possible, taking into consideration the progression of the condition. It is important to provide safeguards against patients making impulsive decisions to end their lives, yet this must clearly be balanced with the imperative to allow timely access to patients at the very end of life. For these reasons, the VIC Branch would support the prescribed period being the 'longest time reasonable' with doctors to make individual decisions about how long this may be, for each individual patient.

Should there be specific offences for those who fail to comply with the requirements in the Act or are the offences of homicide or aiding or abetting suicide appropriate and sufficient?

The VIC Branch would support the creation of new criminal offences relating to the inducement of a person to request or access voluntary assisted dying.

Properly informed

What resources should be developed to support legislative obligations to provide information that would be useful in practice?

While suffering as a result of psychiatric illness is not a basis for accessing voluntary assisted dying, some people with mental illness may need to make decisions regarding their end of life care. Supported decision-making enables and supports people living with mental illness to make their own decisions about their treatment and care. The VIC Branch would therefore encourage the development and dissemination of resources relating to supported decision-making to ensure that medical practitioners are providing appropriate support to help people living with mental illness to make their own decisions.

Confirming a request

Should the legislation prescribe specialist expertise required for medical practitioners to participate in voluntary assisted dying?

The VIC Branch acknowledges that the specialist expertise required for medical practitioners to participate in voluntary assisted dying may vary considerably, depending on the patient and the nature of their condition. As such, the VIC Branch would support legislation that does not include prescriptive requirements about the qualifications of medical practitioners, in line with legislation in other jurisdictions.

Should there be a requirement for a palliative care specialist referral or consultation?

The VIC Branch believes that palliative care should be integrated into the voluntary assisted dying scheme to ensure that patients considering voluntary assisted dying retain access to palliative care. The VIC Branch would therefore support a requirement for patients considering voluntary assisted dying to have at least had the opportunity to consult with a palliative care specialist.

Conscientious objections

How should conscientious objection to voluntary assisted dying operate?

While psychiatrists see the psychiatric assessment and treatment of patients who are considering suicide as a core part of their role, psychiatrists may not wish to take on a ‘gatekeeper role’ in voluntary assisted dying. For example, research shows that while 64% of British psychiatrists agree that psychiatric assessments are important in the context of voluntary assisted dying, only 35% would be willing to carry out such assessments (Shah et al., 1998). The VIC Branch therefore strongly approves of the Parliamentary Committee’s recommendation that health practitioners not be required to participate in voluntary assisted dying against their wishes.

Administering a lethal dose of medication

Are additional safeguards required when a medical practitioner administers the lethal dose of medication and, if so, what safeguards would be appropriate?

The VIC Branch would support a requirement for the undertaking of a final capacity test before a physician-administered lethal dose, akin to a pre-surgical test, where the patient is asked a series of basic questions in the presence of two doctors to ensure that they have capacity to consent to the procedure.

Monitoring the use of a lethal dose of medication

How can a prescribed lethal dose of medication be effectively monitored without placing undue burdens or pressure on people accessing or using the medication?

The VIC Branch supports the steps outlined in the discussion paper to ensure that the lethal dose of medication is appropriately monitored. We would note that it is important not to be dissuaded from additional monitoring mechanisms by the argument that other prescription and household items can cause death. Reducing access to means of suicide has been shown to be one of the most effective approaches to suicide prevention and this medication may pose a greater risk to public safety than other medicines and household items that may be misused to cause death. This is because the lethal dose of medication that would be provided to patients considering voluntary assisted dying is likely to:

- be known to cause a quick and painless death
- be legally and socially sanctioned as a means of suicide
- be easier to ingest
- act faster.

For these reasons, the dose is likely to pose a greater risk to public safety and should be monitored accordingly.

After a person has died

What safeguards are necessary to determine whether or not the person has ingested the lethal dose of medication and to destroy the medication if it has not been ingested?

The VIC Branch suggests that guidelines be developed and provided to families or carers regarding what to do after the person has ingested the lethal dose, including who to notify and what to do with the medication. Guidelines should also be developed and provided to doctors regarding what to do when the person is suspected or known to have taken the lethal dose.

What should be recorded as the cause of death for a person who has ingested the lethal dose of medication?

The VIC Branch suggests consideration of a mechanism whereby notifications of ingestion of the lethal dose resulting in death are made to the Assisted Dying Review Board. This would allow data to be collected while maintaining the possibility of recording the cause of death as arising from the underlying condition.

Additional safeguards

What other additional safeguards could be considered?

The VIC Branch would note the usefulness of linking the oversight of voluntary assisted dying with the Office of Births, Deaths and Marriages to ensure that suicides in the declined group are monitored.

Conclusion

Are there any further issues related to the Parliamentary Committee's recommended framework that require the Ministerial Advisory Panel's consideration?

There is a need for appropriate support to be provided to everyone involved including patients, their families and the clinicians. The VIC Branch would encourage further developments in this area to ensure that everyone involved is supported through the process.

References

Australian Bureau of Statistics (2012) 3303.0 – Causes of Death, Australia. Available at: www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2012~Main%20Features~Age~10010 (accessed 9 February 2017).

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