The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Northern Territory Branch

Northern Territory Government

Consultation on Voluntary Assisted Dying

February 2024

Advocacy and collaboration to improve access and equity

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Royal Australian and New Zealand College of Psychiatrists Northern Territory Branch submission

Northern Territory Government consultation on Voluntary Assisted Dying

About the Royal Australian and New Zealand College of Psychiatrists

The RANZCP has over 8400 members, including more than 5900 qualified psychiatrists (consisting of both Fellows and Affiliates of the College) and over 2400 members who are training to qualify as psychiatrists (referred to as Associate members or trainees). As at January 2024, the RANZCP Northern Territory Branch represents 33 Fellows and 35 Associate trainees.

Acknowledgement of Country

The RANZCP Northern Territory Branch acknowledges the Larrakia (Darwin) people and the Arrernte (Alice Springs) people, the Traditional Owners and Custodians of the land. We honour and respect the Elders past and present, who weave their wisdom into all realms of life.

Acknowledgement of lived experience

We acknowledge the significant contribution of all people with lived experience of mental illness, and the people who care and support them, to the development and delivery of safe, high-quality mental health services.

We recognise those with lived and living experience of a mental health condition, including community members and College members. We affirm their ongoing contribution to the improvement of mental healthcare for all people.

Introduction

The RANZCP Northern Territory Branch welcomes the opportunity to contribute to the Northern Territory Government's consultation on Voluntary Assisted Dying (VAD) in the NT. The recommendations contained within this submission are based on consultation with the RANZCP NT Branch Committee and the RANZCP Aboriginal and Torres Strait Islander Mental Health Committee, as well as on our extensive previous submissions on VAD regulation in other states and territories, and our Position Statement 67: Voluntary Assisted Dying.

Psychiatrists are medical specialists in the field of psychiatry with expertise in the assessment and treatment of mental disorders (including cognitive disorders), suicidal ideation and self-harm, including that occurring in the last six to twelve months of life, and so have a strong interest in this matter.

The Australian community holds a range of views in relation to VAD. This range of views also exists among RANZCP members, and respect for this diversity underpins our position. This submission should not be understood as advocating either for or against the legalisation of VAD in the NT. Rather, it seeks to provide a psychiatric perspective on appropriate safeguards in the event of legalisation.

Recommendations

1. **Medical practitioners must be able to choose.**

   There is a wide diversity of community and medical opinion around VAD. Medical practitioners must be allowed to decide on their level of individual involvement with VAD, in line with relevant legislation.

2. **End-of-life care must include mental health or psychosocial support.**

   As described by the Australian Commission for Quality and Safety in Healthcare's National Consensus Statement: Essential elements for safe and high-quality end-of-life care (the National Consensus Statement), comprehensive end-of-life care must always include mental health or psychosocial support of some kind, regardless of whether VAD is being considered.

   This is especially so because a person's capacity to make decisions may be affected by both mental and physical illness, including a treatable psychiatric condition (see recommendation **4**).

   The primary role of psychiatrists in end-of-life care is to identify mental health conditions that are contributing to suffering, and to treat those conditions in the first instance. Psychiatrists may also provide consultative support to other treating professionals around VAD.[1]

   The ability of psychiatrists and other professionals to support humane and appropriate end-of-life care is affected by severe workforce shortages, described in our Australian pre-budget submission 2024-25 and NT pre-budget submission 2024-25.

3. **Mental illness must not be a basis for VAD.**

   The RANZCP does not consider that mental illness should be a basis for VAD, notwithstanding that rights to autonomy and self-determination are equally owed to people with mental illness. While severe mental illness that is non-responsive to treatment exists, it is rare, and ensuring that a person with severe non-responsive mental illness who identified as experiencing unrelievable suffering had capacity for VAD would pose significant challenges.

4. **Mental capacity assessment and undue influence screening must be required for every patient.**

   Any VAD scheme must ensure patients have the capacity to decide, and that they decide freely and voluntarily. Capacity assessment and undue influence screening (see recommendation **5**) are required for every patient.[2]

   4.1 Capacity assessment should be restricted to medical practitioners with specific training.

   The RANZCP considers that capacity assessments for VAD should only be conducted by medical practitioners (doctors) with specialty training in this area. This requirement also applies to psychiatrists – while psychiatrists do routinely perform capacity assessment for other purposes, capacity assessment for VAD is complex and has specific requirements.[2]

   Due to ethical and legal risk, we recommend that all medical practitioners, including psychiatrists, involved in the administration of any stage of the VAD process should undertake training in the relevant VAD legislation and regulations of their jurisdiction.[2]

5. **Consider human rights risk to people with care needs, including older people and people with disability.**

   5.1 Consider risk of psychological distress and suicide

   Older people and people of any age with disability may have increased healthcare needs or a need for assistance with mobility, communication or activities of daily living. Messaging around VAD must

not appear to give licence to any pressure on these groups to forgo appropriate care. Older people and people with disability may be vulnerable to such messaging due to increased rates of psychological distress and suicide.[3-8] It is important that messaging affirms that older people and people with disability have the same human rights as all people, and their lives have the same intrinsic value.[9, 10]

Suicide prevention measures for older people and people with disability should be considered, noting that suicidality in these groups arises from their specific experiences of life adversity, and thus requires targeted prevention strategies.[7, 11-13]

5.2 Provide disability-appropriate supports for communication and decision-making

The need of some people with disability (such as cognitive disability) for interpersonal or technological supports to exercise their capacity for medical decision-making is not a reason to consider they do not have capacity. Discussions and decisions around VAD must not take place without appropriate supports.

Notwithstanding the right to these supports, some support practices (for instance, where one person speaks for another) introduce risk of misunderstanding or undue influence, and these risks must be carefully considered and managed (refer **5.3**).[2, 14]

5.3 Anticipate and prevent abuse and exploitation

Strong protections are needed to prevent the use of VAD as a strategy of abuse or exploitation towards people with care needs. Known mechanisms of elder abuse were detailed by the Royal Commission into Aged Care Quality and Safety (the Aged Care Royal Commission) and the Australian Law Reform Commission report on Elder Abuse. Known mechanisms of abuse of people with disability were described by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. People with disability have higher lifetime prevalence of experiencing violence and abuse than people without disability.[15]

6. Ensure cultural safety for Aboriginal people.

In previous debate and discussion about VAD in the NT and other jurisdictions, Aboriginal people have expressed that VAD is contrary to the values of Aboriginal cultures and that they fear it will be a mechanism for unlawful killing of Aboriginal people by white authorities.[16-18]

The NT Government consulted with Aboriginal people when developing its previous legislation, and we strongly recommend that it engage again now to ensure that the diversity of Aboriginal perspectives is heard and understood.[19]

We recommend that services, rules and procedures for VAD are:

- co-designed with Aboriginal people.
- designed to be culturally safe and trauma-informed, including recognising the importance of Country and extended kinship groups (mob) for Aboriginal people.[20-22]
- offered in community languages or with interpreter support.
- supported by targeted communications material for Aboriginal people, such as that offered in NSW and Queensland.
- where possible and considered acceptable, offered on Country, by Aboriginal staff and through local Aboriginal-controlled organisations.

7. Dementia must not be a basis for VAD.

People living with dementia experience heightened risk of suicide, especially for dementia in early stages or with onset under the age of 70.[23, 24] They need good-quality assessment, care and support, as described in the RANZCP evidence review of Psychiatric service delivery for older people with mental disorders and dementia and the RANZCP-endorsed, Cognitive Decline Partnership Centre's Clinical practice guidelines and principles of care for people with dementia.

The Aged Care Royal Commission detailed serious neglect of Australians with dementia living in the community and in residential care, causing significant avoidable suffering. VAD is not an acceptable solution to avoidable suffering.

The assessment of capacity for VAD is extremely complex in dementia. Often, a person with sufficiently advanced disease to qualify for VAD may not have capacity to request it.[2] Prognoses offered upon early diagnosis or in early disease are inherently unreliable, and emerging treatments may also change previously offered prognoses.[25] For these reasons, the RANZCP does not support dementia as a reason to request VAD.

8. Ensure access to quality care at the end of life.

Territorians have the right to timely and equitable access to properly resourced, high-quality palliative care and end-of-life care, whether in a hospice, hospital or home-based setting, and whether in a metropolitan, or in a rural, regional or remote location, per the National Consensus Statement. VAD is not a substitute for humane end-of-life care.

The Aged Care Royal Commission found that the experience of death and dying for many older people with mental health conditions across Australia, particularly those in nursing homes, constituted abuse by neglect, and rose to the level of human rights violation. A just-released population-level study of Australian long-term care has found only 44.1% compliance with end-of-life care quality indicators.[26]

Specialist palliative care services in the NT are currently limited to two facilities, in Darwin and Alice Springs,[27] and current figures put the number of specialist palliative care physicians in the NT as too low to be countable.[28] Research shows that Aboriginal people in the NT especially want to receive palliative care at or near home, on Country, but are frequently unable to.[29, 30] The palliative-care patient population of the NT has unique features, containing many more people with life-threatening chronic disease than elsewhere (where cancer is more usual), reflective of the prevalence of chronic disease and shortened lifespan among Aboriginal people in the NT. People with chronic disease can experience improved pain management, symptom control and indeed increased life expectancy with access to appropriate palliative care.[30]

Severe medical workforce shortages contribute to these issues, particularly in regional, rural and remote areas of the NT.[31, 32] The RANZCP's Australian pre-budget submission 2024-25, NT pre-budget submission 2024-25 and Rural Psychiatry Roadmap make detailed recommendations on how to grow the psychiatric and mental healthcare workforce.

Funding for properly developed palliative and end-of-life care services must be provided prior to the introduction of VAD, to provide an equitable alternative to people suffering from terminal illness.

Conclusion

The RANZCP NT Branch appreciates the opportunity to the Northern Territory Government's consultation on VAD in the NT. If you have any questions or wish to discuss any details in this submission further, please contact Nada Martinovic, Policy and Advocacy Adviser via email at ranzcp.nt@ranzcp.org.

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