The Royal Australian & New Zealand College of Psychiatrists

Inquiry into the NSW Voluntary Assisted Dying Bill 2021 – November 2021

Improving the mental health of the community

Introduction

The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide a submission to the NSW Legislative Council Standing Committee on Law and Justice's Inquiry into the Voluntary Assisted Dying (VAD) Bill 2021.

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand. It is a membership organisation that trains doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The College has over 7300 members, including more than 5300 qualified psychiatrists and around 2000 members who are training to qualify as psychiatrists. RANZCP NSW Branch represents more than 1300 Fellows and 500 trainees.

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 12 months of life.

RANZCP background in end-of-life care and VAD debates

The RANZCP is guided on policy issues by a range of expert committees and members with particular expertise. In September 2020, the RANZCP released its Position Statement 67: Voluntary Assisted Dying Many of its members are subject experts in relation to capacity, consent, human rights and quality care at the of end of life (see Peisah et al, 2019; 2021; Ryan et al, Wand et al). Given this expertise, the RANZCP is uniquely placed to contribute to the debate about legislative reform in relation to VAD and has a responsibility to do so.

To date, the RANZCP has informed both the Australian and New Zealand VAD debate and legislation on VAD, with a raft of submissions including but not limited to:

- 6 April 2017- RANZCP VIC response to the Ministerial Advisory Panel discussion paper on the Victorian Voluntary Assisted Dying Bill
- 15 February 2018: RANZCP NZ Submission to Justice Select Committee on End of Life Choice Bill
- 17 April 2019: RANZCP QLD Submission to Inquiry into aged care, end of life and palliative care, and voluntary assisted dying
- 10 July 2020: RANZCP WA Submission to Joint Select Committee on Palliative Care July 2020

Common themes

Common to both the VAD Position Statement and these submissions are a number of consistent issues in relation to VAD which have been highlighted by the RANZCP, including:

1. **There is a wide diversity of community and medical opinion around VAD**. The RANZCP acknowledges the importance of medical practitioners being allowed to make their own ethical decisions with regard to their involvement with VAD, in line with relevant legislation.

2. **The role of the psychiatrist** includes specific skills and expertise in identifying psychiatric illnesses and to assess suicidal ideation in patients, including the terminally ill. Psychiatrists may have a role with patients who are considering or wish to discuss VAD through the identification and treatment of mental illness and, when appropriate, making recommendations for patients' mental health treatment and care. The primary role of psychiatrists is to facilitate the provision of good-quality, comprehensive and accessible healthcare, including end-of-life care. There is a need to consider mental health as a core factor in comprehensive end-of-life care and the role of psychiatrists in end-of-life care is to assess and treat mental health conditions that are contributing to suffering, and to treat those conditions in the first instance. A person's capacity to make decisions may be affected by both mental and physical illness, including a treatable psychiatric condition.

3. **VAD and people with mental disorders.** The RANZCP suggests that mental illness should not be the basis for VAD, notwithstanding the recognition that rights to autonomy and self-determination are equally owed to people with mental illness. While unrelievable psychiatric suffering exists, it is rare, and ensuring that a person with mental illness and unrelievable suffering has capacity for VAD poses significant challenges.

4. **The issue of capacity is central to the discussion on VAD**. Any VAD scheme must include important safeguards to ensure patients have both the capacity to make the decision and to do so freely and voluntarily. Therefore, both capacity assessment and undue influence screening should be required for every patient applying for VAD.[1] While psychiatrists receive general training in capacity assessment, capacity assessment for VAD is extremely complex and requires specific training. An assessment of capacity does not necessarily require a psychiatrist. Given the complexity and consequences of the decision to choose VAD,[2] and the significant shortfalls in knowledge of capacity assessments amongst doctors,[3, 4] the RANZCP considers that capacity assessments for VAD should only be conducted by medical practitioners (doctors) with specialty training in this area. Additionally, given the known lack of knowledge of death law amongst doctors,[5] the RANZCP advises that all medical practitioners, including psychiatrists, involved in the administration of any stage of the VAD process should be familiar with the relevant VAD legislation and regulations of their jurisdiction.

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[1] Peisah C, Sheahan L, White B. (2019) The biggest decision of them all - death and assisted dying: capacity assessments and undue influence screening. Intern Med Journal 49(6):792-796.
[2] Ibid., Footnote 1 .
[3] Peisah C. Yaffa Lerman Y. Herrmann N., Rezmovitz J Shulman K (2021) Piloting the Global Capacity Education e-Tool: can capacity be taught to health care professionals across different international jurisdictions International Psychogeriatrics 33(9):913-916.
[4] Young G, Douglass A, Davison L. What do doctors know about assessing decision-making capacity? N Z Med J. 2018 Mar 9;131(1471):58-71.
[5] White B, Willmott L, Cartwright C, Parker MH, Williams G. Doctors' knowledge of the law on withholding and withdrawing life-sustaining medical treatment. Med J Aust. 2014 Aug 18;201(4):229-32.

5. **VAD and older people**. The RANZCP has previously emphasised the need for careful consideration of the potential impact of VAD on older persons, due to their high risk of suicide, particularly amongst older men. Increasing ageism across society and health[6] compounded during the COVID pandemic[7] has intensified older people's perceived burdensomeness, considered to be a factor fuelling suicidal ideation.[8] VAD should not be used as a means for relieving family or societal burden.[9]

   The RANZCP also expresses concern that the introduction of VAD could have unintended consequences, including possible increased pressure on marginalised or disadvantaged groups to die rather than be a burden. This renders older people vulnerable to undue influence and elder abuse in the VAD context.[10] It has been suggested that for some older people, the choice to end one's life is the end point of ageism and other Human Rights violations.[11] Further, it has been suggested that VAD legislation must be accompanied by suicide prevention programmes for older people that are bespoke to older people and not an ageless, "one size fits all" approach.[12]

6. **VAD and people with dementia**. People living with dementia are also at risk of suicide, especially those with dementia in its early stages,[13] and those with onset under the age of 70, with symptoms of depression and anxiety. The RANZCP strongly supports good quality assessment, care and support mechanisms for people with dementia. As evidenced by the findings of the recent Royal Commission into Aged Care Quality and Safety[14], these are not always available, leading to serious neglect of people with dementia living in the community and in residential care. However, VAD is not a solution to this neglect. The complexity and consequences of the decision to request VAD renders assessment of capacity for VAD extremely complex in dementia.[15] For this reason, the RANZCP does not support that dementia (which is a neurodegenerative disease) be a reason to request VAD.

7. **Equitable access to quality care at the end of life**. Palliative care is intended to provide the best quality of life possible during the final stages of patients' illnesses and allow patients to die with dignity. The right to quality end-of-life care is a fundamental

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[6] Chang ES, Kannoth S, Levy S, Wang SY, Lee JE, et al. (2020) Global reach of ageism on older persons' health: A systematic review. PLOS ONE 15(1): e0220857.
[7] Ayalon L, Peisah C, Lima CM, Verbeek H, Rabheru K. Ageism and the State of Older People With Mental Conditions During the Pandemic and Beyond: Manifestations, Etiology, Consequences, and Future Directions. Am J Geriatr Psychiatry. 2021 Jul 7: S1064-7481(21)00382-1.
[8] Wand A., Peisah C. Draper B, Brodaty H (2018) Why do the very –old self harm? A qualitative study. American Journal of Geriatric Psychiatry (26): 862-871.
[9] Peisah C, Sampson EL, Rabheru K, Wand A, Lapid M. The human rights of older people with mental health conditions and psychosocial disability to a good death and dying well *The American Journal of Geriatric Psychiatry* 2021 May 30:S1064-7481(21)00342-0.
[10] Wand A., Peisah C. Draper B, Brodaty H (2018) The nexus between elder abuse, suicide, and assisted dying: the importance of relational autonomy and undue influence Macquarie Law Journal 18: 79-92
[11] Wand A, Verbeek H, Hanon C, Augusto de Mendonça Lima,C, Rabheru K, Peisah C. Is Suicide the End Point of Ageism and Human Rights Violations? *The American Journal of Geriatric Psychiatry* 2021 Jun 10:S1064-7481(21)00352-3.
[12] Wand AP, McKay R. The Zero Suicide Framework requires adaptation to include older adults. Aust N Z J Psychiatry. 2021 Apr;55(4):427-428
[13] Choi JW; Lee KS; Han E Suicide risk within 1 year of dementia diagnosis in older adults: a nationwide retrospective cohort study. Journal of Psychiatry & Neuroscience. 46(1):E119-E127, 2021 01 04.
[14] Royal Commission into Aged Care Quality and Safety Final Report, 1 Mach 2021
[15] Draper B, Peisah,C., Snowdon J, Brodaty H. Early dementia diagnosis and the risk of suicide and euthanasia Alzheimer's & Dementia 6 (2010), pp. 75-82.

human right owed to all, including those with mental health disorders.[16] All Australians should have 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. VAD should not be used as a substitute for humane end-of-life care.[17]

The experience of death and dying for many older people with mental health conditions, particularly those residing in nursing homes, has been demonstrated to have constituted elder abuse by neglect, and violated the right to be protected against abuse or torture and cruel, degrading treatment.[18]

Under-resourcing of palliative care, particularly that in residential care facilities, results in such neglect, an observation endorsed by the Royal Commission. Significant workforce shortages among palliative care physicians, geriatric medicine physicians and psychiatrists are particularly acute in rural areas.

Funding for properly developed palliative care services must be provided prior to the introduction of VAD, in order to provide an equitable alternative to people suffering with a terminal illness. Without adequate resourcing of, and access to, palliative care, VAD legislation, arguably, presents a perverse incentive for patients to choose to end their life, instead of being offered adequate palliative care. The RANZCP has concerns regarding funding of a VAD scheme at the expense of making improvements to other end-of-life care options for Australians.

8. **VAD and people with disability**. The same issues regarding under-resourcing and other access limitations to high quality end-of-life care apply to people with disability.[19] The RANZCP strongly recommends careful scrutiny of the implications of VAD for people with a disability, particularly for those residing in residential facilities.

Comments on the NSW VAD Bill

We note that NSW, as the only Australian State not yet to have passed VAD legislation,[20] has had the benefit of the precedent Acts in other States, as well as in New Zealand, in drafting its Bill.

Much of this proposed NSW legislation appears to be aligned with those Acts. In particular, the Bill is closely modelled on the *Voluntary Assisted Dying Act 2017* (Vic) which has now been in operation in Victoria since 19 June 2019. The Victorian Act has served as the model for all of Australia's voluntary assisted dying legislation.[21] We offer some specific comments on the NSW Bill below.

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[16] Peisah C, Sampson EL, Rabheru K, Wand A, Lapid M. The human rights of older people with mental health conditions and psychosocial disability to a good death and dying well *The American Journal of Geriatric Psychiatry* 2021 May 30:S1064-7481(21)00342-0.

[17] Ibid. Footnote 15

[18] Royal Commission into Aged Care Quality and Safety Final Report, 1 Mach 2021

[19] Ibid., Footnote 15

[20] The Australian Capital Territory and Northern Territory are prohibited from making laws to facilitate assisted dying by the *Euthanasia Laws Act 1997* (Cth).

[21] See: *Voluntary Assisted Dying Act 2021* (Qld); *Voluntary Assisted Dying Act 2021* (SA); *End-of-Life Choices (Voluntary Assisted Dying) Act 2021* (Tas); *Voluntary Assisted Dying Act 2019* (WA).

PART 1 Preliminary

Division 2 Principles

Cl 4 Principles

(1) A person exercising a power or performing a function under this Act must have regard to the following principles—

(a) every human life has equal value …,

(b) a person's autonomy, including autonomy in relation to end of life choices, should be respected,

(c) a person has the right to be supported in making informed decisions about the person's medical treatment and should be given, in a way the person understands, information about medical treatment options, including comfort and palliative care and treatment,

(d) a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life,

(e) a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained,

(f) a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding the person's care, treatment and end of life should be encouraged and promoted,

(g) a person should be supported in conversations with the person's health practitioners, family, carers and community about care and treatment preferences,

(h) a person is entitled to genuine choices about the person's care, treatment and end of life, irrespective of where the person lives in New South Wales and having regard to the person's culture and language,

(i) a person who is a regional resident is entitled to the same level of access to voluntary assisted dying as a person who lives in a metropolitan region,

(j) there is a need to protect persons who may be subject to pressure or duress, Note— See the definition of pressure or duress in the Dictionary in Schedule 1.

(k) all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

Comment: Supported with amendments

The RANZCP notes that these principles are in accordance with human rights to autonomy, respect for will and preferences, equitable access to the highest quality of health care at the end of life and supported decision-making with provision of adequate understandable information.

Section 4 (1)(g) is commendable in its respect for the family and relationships. The RANZCP has previously suggested that Parliamentary Committees consider whether the application for VAD should mandate formal notification of next of kin prior to the assisted death. For example, the Victorian Act requires a medical practitioner, with the person's consent, to take all reasonable steps to explain to a family member all relevant clinical guidelines about VAD and a plan in respect of the self-administration of the assisted dying substance.

In light of serious access issues and neglect with respect to palliative care provision as outlined above, we would add two clauses, in addition to Clause 4 1(i):

> *(j) a person who is a rural/regional resident is entitled to the same level of access to high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life, as a person who lives in a metropolitan area,*
>
> *(k) a person who is a resident of an aged care facility or residential disability facility is entitled to the same level of access to high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life, as a person who not a resident of a facility.*

Division 3 Interpretation

Cl 6 Decision-making capacity

(1) For the purposes of this Act, a patient has decision-making capacity in relation to voluntary assisted dying if the patient has the capacity to—

> *(a) understand information or advice about a voluntary assisted dying decision required under this Act to be provided to the patient, and*
>
> *(b) remember the information or advice referred to in paragraph (a) to the extent necessary to make a voluntary assisted dying decision, and*
>
> *(c) understand the matters involved in a voluntary assisted dying decision, and*
>
> *(d) understand the effect of a voluntary assisted dying decision, and*
>
> *(e) weigh up the factors referred to in paragraphs (a), (c) and (d) for the purposes of making a voluntary assisted dying decision, and*
>
> *(f) communicate a voluntary assisted dying decision in some way.*

Comment: Supported

The RANZCP concurs with this operationalised definition of capacity.

Division 4 Other provisions

Cl 9 Registered health practitioner may refuse to participate in voluntary assisted dying

Comment: Supported

Aligned with other legislation, the RANZCP notes that this provision acknowledges the importance of medical practitioners being allowed to make their own ethical decisions with regard to their involvement with VAD.

PART 2 Requirements for access to voluntary assisted dying

Cl 16 Eligibility criteria

(1) The following criteria must be met for a person to be eligible for access to voluntary assisted dying—

(a) the person is an adult, …

…

(d) the person is diagnosed with at least 1 disease, illness or medical condition that—

(i) is advanced, progressive and will cause death, and

(ii) will, on the balance of probabilities, cause death—

(A) for a disease, illness or medical condition that is neurodegenerative, —within a period of 12 months, or

(B) otherwise—within a period of 6 months, …….

Comment: Supported with amendment

For reasons detailed above, the RANZCP suggests amending clause 16 (1)(d)(ii)(A) to clarify that dementia is excluded from neurodegenerative diseases. It is the RANZCP's understanding that such provisions were originally intended to refer to neurodegenerative conditions, such as motor neurone disease, and not dementia.

PART 3 Requesting access to voluntary assisted dying and assessment of eligibility

Division 1 Eligibility requirements for medical practitioners

Cl 18 Eligibility to act as coordinating practitioner or consulting practitioner

A medical practitioner is eligible to act as a coordinating practitioner or consulting practitioner for a patient if— .

(a) the medical practitioner - … , and

(b) the medical practitioner has completed the approved training,

Comment: Supported

The RANZCP notes that eligibility for both *coordinating and consulting practitioner* acting under the legislation is contingent upon completion of the approved training. College members were consulted in relation to the training for the Victorian legislation, and provided resources for such. The RANZCP advises using similarly assiduous training, albeit adapted to the NSW legislation as required.

Division 2 First request

Cl 19 Person may make first request to medical practitioner

(1) A person may make a request to a medical practitioner for access to voluntary assisted dying.

(2) The request must be—

(a) clear and unambiguous, and

(b) made during a medical consultation, and

(c) made in person or, if that is not practicable, in accordance with section 182(1)(a).

(3) The person may make the request—

(a) verbally, or

(b) in another way. Example for paragraph (b)— by use of gestures

(4) The person may make the request with the assistance of an interpreter

Comment: **Supported**

The RANZCP notes that the requirement that the request be made by the person during a medical consultation (with an offence incurred if otherwise, and the person is induced to make a request) is an important safeguard against undue influence and abuse.

Division 3 First assessment

Cl 27 Referral for opinion—other matters

(2) The coordinating practitioner must refer the patient to—

(a) if the coordinating practitioner is unable to decide whether the patient has decision-making capacity in relation to voluntary assisted dying—a psychiatrist or another registered health practitioner who has appropriate skills and training to make a decision about the matter, or

(b) if the coordinating practitioner is unable to decide whether the patient is or is not acting voluntarily or whether the patient is or is not acting because of pressure or duress—a psychiatrist or another registered health practitioner or person who has appropriate skills and training to make a decision about the matter.

Comment: Supported with amendment

The RANZCP notes the current phrasing is ambiguous, and may be interpreted to suggest that psychiatrists already have the "appropriate skills and training" to make decisions about a person's capacity and whether a person is acting voluntarily. Psychiatrists do not necessarily have these skills. It therefore needs to be clarified that both the psychiatrist or another registered health practitioner need to have "appropriate skills and training to make a decision about the matter".

Further, for the reasons outlined earlier with regards to the complexity of this role, and given the ambiguity and lack of operationalisation of "appropriate skills and training", the RANZCP suggests adding a clause that specifies "having completed the approved requisite training."

Cl 30 Recording and notification of outcome of first assessment

(4) The first assessment report form must include the following—

(a) the patient's name, date of birth and contact details, …

(k) the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment,

(l) a statement confirming the patient has been advised of the palliative care and treatment options available to the patient and the likely outcomes of the care and treatment, …

Comment: Supported

In line with other schemes, the RANZCP notes that this certification ensures that the patient is aware of, has considered, and has access to, viable options of palliative care as alternatives to VAD.

Cl 31 Referral for consulting assessment if patient assessed as eligible

If the coordinating practitioner assesses the patient as eligible for access to voluntary assisted dying, the practitioner must refer the patient to another medical practitioner for a consulting assessment.

Comment: Supported, noting potential ambiguity

The RANZCP notes the importance of having two separate practitioners involved in the assessment process. Having said this, clause 31 appears to be obscured by the preceding provisions in relation to the coordinating practitioner, which may lead to ambiguity about this and the crucial importance of the second, consulting practitioner.

Division 4 Consulting assessment

Cl 38 Referral for opinion – other matters

(2) The consulting practitioner must refer the patient to –

(a) if the consulting practitioner is unable to decide whether the patient has decision-making capacity in relation to voluntary assisted dying – a

psychiatrist or another registered health practitioner who has appropriate skills and training to make a decision about the matter, or …

(b) if the consulting practitioner is unable to decide whether the patient is or is not acting voluntarily or is or is not acting because ***of pressure or duress*** *– a psychiatrist or another registered health practitioner or person who has appropriate skills and training to make a decision about the matter*.

Comment: Supported with amendment

The comments made above in relation to Cl 27 (Division 3 – First assessment) apply equally to this clause.

The current phrasing is ambiguous, and should be rephrased to clarify that both psychiatrists and other registered health practitioners need to have the skills and training specific to VAD. The RANZCP further suggests that the phrase "appropriate skills and training" be amended to a phrase that specifically refers to completion of approved requisite training.

Part 10 Voluntary Assisted Dying Board

Comment: **Supported**

The RANZCP notes that the establishment of a Voluntary Assisted Dying Board is consistent with other schemes which have established such Voluntary Assisted Dying Review Boards to oversee VAD, to review every case and make suggestions for changes or improvements in the law.

As with similar schemes in other jurisdictions, any VAD scheme needs to be carefully regulated and monitored to ensure compliance with the law, and systematically reviewed on a regular basis.

The RANZCP notes that the proposed composition of the Board is five members, who need to have "knowledge, skills or experience relevant to the Board's functions".

The RANZCP recommends that consideration be given to psychiatric representation on the Board.