The Royal Australian & New Zealand College of Psychiatrists

Queensland Branch

17 April 2019

Committee Secretary
Health Committee
Parliament House QLD 4000

By email to: careinquiry@parliament.qld.gov.au

Dear Secretary

**Re: Inquiry into aged care, end-of-life and palliative care, and voluntary assisted dying**

The Royal Australian and New Zealand College of Psychiatrists Queensland Branch (RANZCP QLD Branch) welcomes the opportunity to provide a submission to the Inquiry into aged care, end-of-life and palliative care, and voluntary assisted dying.

We consider the primary role of medical practitioners in end-of-life care is to facilitate the provision of good quality patient-centred care. We recognise that voluntary assisted dying is a complicated ethical issue, and one that is best considered by the wider Queensland community.

The RANZCP QLD Branch considers the aged care system does not currently meet the needs of older Queenslanders, especially those with mental illness and related disorders (e.g. dementia). We are therefore pleased that both the Commonwealth and the Queensland government are focussing on the under-resourced aged care sector.

The aged care sector needs a significant boost in funding overall, including funding to increase the number of residential aged care places, improve the staff to resident ratios, and improve the skills and ongoing training of staff. It is essential this occurs before any voluntary assisted dying legislation is introduced, to ensure Queenslanders have a viable alternative to choosing to end their life.

We have prepared detailed responses to the issues paper questions, concentrating on the topics of aged care and voluntary assisted dying (overleaf).

If you would like to discuss any of the issues raised in our submission, please contact Bianca Phelan, QLD Branch Policy Officer via qldpolicy@ranzcp.org or by phone on (07) 3852 2977.

Yours sincerely

Prof Brett Emmerson AM
**Chair, RANZCP QLD Branch**

PO Box 261, RBH Post Office QLD 4029 Australia
T +61 7 3852 2977 F +61 7 3852 2199
ranzcp.qld@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

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# Submission to Inquiry into aged care, end-of-life and palliative care, and voluntary assisted dying

April 2019

working with the community

PO Box 261, RBH Post Office QLD 4029 Australia
T +61 7 3852 2977 F +61 7 3852 2199
ranzcp.qld@ranzcp.org www.ranzcp.org
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## Aged care in Australia

There is increasing evidence that 'successful' ageing is intrinsically linked with maintaining good mental health. As the Inquiry's issues paper points out Queensland's population is rapidly increasing. By 2026 the number of Queenslanders aged over 65 years is expected to reach 1 million, and by 2066 between 2 and 2.7 million (QGSO, 2018). Meanwhile, the Queensland population aged over 85 years while currently small in numbers, is growing rapidly. It has more than doubled in the 20 years to 85,000 in 2016, and is projected to be between 115,000 and 120,000 by 2026, and between 406,000 and 679,000 by 2066 (QGSO, 2018).

Older people are disproportionately high users of health and social services. The majority of older people have neither a mental illness nor dementia. However if they have a mental illness, they are likely to also have significant social and physical health problems. Even mild mental illness can have a significant impact on an older person's health, function, quality of life, use of health services, and outcomes of health interventions. While dementia may not be wholly classified as a mental health issue, the common psychiatric complications of dementia require significant involvement of mental health professionals in care, treatment and support.

Mental illness is often unrecognised by individuals, family and health care professionals, who may wrongly attribute symptoms of treatable mental illness to the irreversible effects of ageing or to physical or environmental changes. There is a tendency to refer relatively few older people with mental illness for specialised psychiatric treatment. Whilst early old age is associated with lower mental health related costs; treatment costs for mental illness increase substantially with age in the population over 75 years old.

Most older people wish to live in their own homes and do so. Entry to residential aged care is a significant transition when required, with significant economic and personal cost. Home based mental health treatment for older people can reduce entry to hospital and residential care, improve quality of life for older people, and reduce healthcare costs. Both reduction in access to appropriate mental health care, and absence of appropriate community alternatives to residential care, increase the risk of inappropriate entry to residential aged care. Furthermore, people with mental illness appear to then have an increased risk of entry to residential care facilities that have poorer standards of care provision (RANZCP, 2015). Effective treatment improves the quality of life of significant numbers of people and a number, if treated, could be discharged to less costly and more appropriate community facilities or services (RANZCP, 2015).

Older people require the same spectrum of mental health care services as described for the whole population. That is, from mental health promotion and early intervention, through to community mental health care (including both crisis services and within residential aged care); acute inpatient care; liaison services in non-mental health hospital settings; and subacute and/or extended care in settings most appropriate to the older person's needs.

The Royal Australian and New Zealand College of Psychiatrists, Queensland Branch (RANZCP QLD Branch) is deeply concerned about reports of abuse and neglect occurring in residential aged care facilities (RACFs), and strongly supports the introduction of the Royal Commission into Aged Care Quality and Safety. The Queensland government should refer to the findings of the Commission as part of its Inquiry into the aged care sector in Queensland.

## Issues paper questions

The RANZCP QLD Branch has chosen to respond to four of the Inquiry's issues paper questions on aged care.

**Q.1 Is the aged care system meeting the current needs of older Queenslanders, including those people with special needs? Why or why not?**

The RANZCP QLD Branch considers the aged care system does not currently meet the needs of older Queenslanders, especially those with mental illness and related disorders (e.g. dementia). We have identified a number of key issues which we consider contribute to this including:

- long wait time for aged care packages
- inadequate care packages for a person's level of need
- long wait time for access to RACFs and aged care services, particularly in rural and regional areas
- inadequate funding of aged care services and poorly resourced services
- poor access to specialised care for people with intellectual and developmental disorders (IDD), mental illness and neurodegenerative disorders (e.g. dementia, Alzheimer's)
- lack of health staff and RACF staff with training, education and experience in dealing with behavioural management, dementia and mental health issues
- poor availability of out-of-hours care (overnight, weekend and public holidays)
- high entry fees to access RACFs.

With regards to these issues, the RANZCP QLD Branch is aware the federal government is responsible for the aged care system in Australia, yet note that Queensland Health retains responsibility also as an approved provider under the *Aged Care Act 1997* for 63 aged care services in Queensland.

We would like to point out that Aboriginal and Torres Strait Islander peoples suffer levels of mortality, morbidity and compromised wellbeing far in excess of non-Indigenous Australians. This reflects issues of social injustice, particularly persistent social, economic disadvantage and the historical legacy of colonisation with its destruction of Indigenous culture. It is essential that aged care staff and health professionals providing support or mental health care recognise and respect the roles of older Aboriginal and Torres Strait Islander peoples and are aware that concepts of mental health are integrated into broader concepts of wellbeing within their cultures. All staff and health visitors should be aware of principles for working with Aboriginal and Torres Strait Islander peoples, and respond with flexibility in access and service delivery to meet their needs.

At present, there are limited appropriate care options for older people from culturally and linguistically diverse (CALD) backgrounds and Lesbian, Gay, Trans and Gender Diverse, and Intersex (LGBTI) peoples in Queensland. The Australian Government's Diversity Framework seeks to embed diversity in the design and delivery of aged care. However, our members have reported that there is still a lack of sensitivity to the diverse needs of older Queenslanders in the delivery of aged care, particularly in RACFs.

**Q5. Are there enough residential aged care places (beds) available in aged care facilities, in areas and at the levels of care that are required?**

We believe Queensland has a clear shortage of aged care beds. We are particularly concerned that many older people are placed in acute hospital beds for prolonged periods of time because there are no suitable or secure placements available in RACFs. Psychiatrists report difficulties in sourcing beds for this cohort and are concerned about the risk of bed blocking in hospitals. In particular, people with dementia with extreme behavioural and psychological symptoms of dementia (BPSD) (e.g. physical violence) and people with dementia with very severe BPSD (e.g. severe depression, suicidal tendencies, physical aggression) often remain in inappropriate settings for years, such as general adult inpatient units and mental health inpatient units.

Also, as identified above in the response to question 1, there are long waiting lists to access beds in RACFs, particularly in rural and regional areas.

Australia has a large number of young people under the age of 65 in RACFs rather than more suitable residential care which caters to their disability and/or complex health needs. Nationally there are approximately 6000 people under the age of 65 in RACFs, this includes 1179 under the age of 55, 188 under the age of 45, and 30 under the age of 35 (AG, 2019). We note the federal government's has recently introduced the 'Young People in Residential Care – Action Plan' which aims to reduce the number of younger people living in aged care and help them access more age appropriate housing and supported living options. The National Disability Insurance Scheme is also assisting in reducing the number of young people entering into RACFs.

Placement of young people in RACFs is highly inappropriate for a multitude of reasons. These facilities are designed for an older aged cohort who are coming to the end of their life span. Loneliness, boredom and grief characterises many young people's experiences of RACFs. Despite the federal government's newly introduced action plan and the efforts of the National Disability Insurance Agency, we call upon the Queensland government to work with these stakeholders to prioritise the creation of more appropriate specialised housing, in consultation with this cohort, their families and carers.

**Q11. Are suitable health care services being provided within residential aged care settings and/or aged care providers?**

The RANZCP QLD Branch believes the health care services provided in many of the RACFs are insufficient, particularly the services and programs for people with dementia, mental illness and BPSD. To improve the health and mental health services provided within RACFs there is a need to:

- increase patient access to general practitioners (GPs) and allied health professionals
- increase the numbers of registered nurses
- provide access to multidisciplinary teams
- increase RACF and health staff to patient ratio
- improve training and education of RACF and health staff, particularly in dealing with behavioural management, dementia, and mental health issues
- improve access to specialist mental health care
- introduce mechanisms to manage the over prescription of psychotropic drugs to people in RACFs

- improve communication between RACFs and acute mental health units (which older people are sent to when exhibiting behavioural disturbances).

People in Australian RACFs, similar to those in many countries, have high rates of sleep disturbance, anxiety, depression, and BPSD (Westbury et al., 2018). Professional guidelines advocate for non-pharmaceutical management for these conditions as the first port of call. For instance, RANZCP recommends patients with dementia and depression should receive psychosocial interventions in the first instance (RANZCP Position Statement 81), and considers the first-line approach to management of BPSD is a person-centred psychosocial, multidisciplinary treatment plan (RANZCP Professional Practice Guideline 10). However in most cases psychotropic medications (e.g. antipsychotics, antidepressants) are prescribed, and it is widely established that Australia has inappropriate and high rates of psychotropic medication being used in RACFs (Westbury et al., 2018; Brimelow et al., 2018).

Looi et al. (2013) argue that the overuse of psychotropic medication is a symptom of systemic problems in the provision of mental health care in RACFs. These problems include:

- inadequate levels of poorly remunerated staff with limited mental health and behavioural management training
- facilities without ready access to multidisciplinary input from psychiatrists, GPs, clinical older adult psychologists and other specialist mental health workers
- activity programs that are insufficiently tailored to the specific needs of people with dementia
- physical design limitations that do not provide a supportive prosthetic or therapeutic environment for people with dementia.

These problems require broad scale interventions, such as the provision of services for the prompt assessment of people with mental illness, and changes in the design and organisational culture of RACF towards improving the mental wellbeing of residents (Looi et al., 2013).

The RANZCP QLD Branch recommend that RACFs should be designed to support the specific needs of people with dementia and mental illness and maximise quality of life. People with very high care needs related to BPSD and mental illness require specially designed programs within residential care. Success factors of such programs include:

- committed service providers with effective and committed leadership
- well-designed facilities that provide a prosthetic and therapeutic environment
- passionate and skilled staff, with appropriate training, experience and expertise
- use of psychosocial approaches and alternatives to medication
- the ability to access on-call staff support when required
- clear partnership with psychiatric services complemented by the services of GPs, psychologists, nursing and other allied health staff.

**Q16. What are the key priorities for the future?**

Our priorities for improvements to the aged care sector are:

- increase the number of community-based and home-based aged care services, especially in rural and regional areas
- increase the number of aged care packages
- ensure level of aged care packages are appropriate to people's needs
- increase the number of RACFs beds
- increase staffing levels altogether, especially the number of registered nurses, allied health staff, and visits by GPs
- introduce appropriate minimum health and RACF staff to patient ratios
- improve training of all RACF staff and health staff, particularly in IDD, behavioural management, dementia, mental health issues, and Aboriginal and Torres Strait Islander peoples issues
- increase the number of GP incentives/remuneration for RACF visits and home care visits
- improve integration of care and services between RACFs, hospitals, and community services, whether they are publicly or privately provided
- establish multidisciplinary teams in aged care services
- adopt evidence-based activity programs specific to the needs of the person
- provide home-like environments in RACFs which are physically supportive, dementia-friendly, support social interactions, and access to nature
- increase resources to support people with high care needs e.g. complex behaviours, IDD
- introduce regular inspections/reviews of all types of aged care services
- improve access to mental health services for home-based and community care.

The RANZCP QLD Branch would like to highlight the importance of providing appropriate home-based care and support for older people to stay in their homes, especially when this is their preference. Staying at home enables older people to maintain connections with family, friends, communities and their place of residence. We are also concerned for people living in rural and regional areas who are unable to access RACFs close to home and are forced to separate from family, friends, and communities.

Given Queensland's geographical challenges, the Queensland government should consider developing innovative support, financial and health care models to enable people to live in their homes longer. For instance, technology could be utilised for remote monitoring or telehealth, and housing, tax, and financial barriers to staying at home or relocating to a suitable home could be removed.

The RANZCP QLD Branch is concerned aged care services appear to vary widely in terms of standard of care. We support the establishment of a thorough national quality framework for the aged care sector that aims to promote continuous improvement in the quality of care and service provision, similar to that of the National Quality Framework for early childhood education and care.

We note that the newly established Aged Care Quality and Safety Commission introduced Aged Care Quality Standards in January 2019. Organisations providing Commonwealth subsidised aged care services will be assessed and must be able to provide evidence of their compliance with, and

performance against the standards by 1 July 2019. The RANZCP QLD Branch is disappointed the new standards do not go further to address the needs of a diverse Australian population or their mental health and related disorders. For instance, the standards do not introduce appropriate minimum staff to resident ratios, or stipulate staff training standards for IDD, behavioural management, mental health and related disorders, and LGBTI and CALD issues.

Under the new standards consumers can access accreditation reports about residential aged care providers, it would be useful for consumers to access assessment ratings at a glance, similar to those provided by the National Quality Framework for Early Childhood Education and Care. We suggest the inquiry refer to the progress of these new standards.

Access to mental health care in RACFs is essential to helping older people maintain good mental health and wellbeing. The RANZCP QLD Branch strongly recommends the Queensland government advocate to federal government to:

- ensure that people living in RACFs have full access to the Medicare Benefits Scheme, in particular the mental health items
- mandate a formal aged care accreditation standard requiring all aged care providers to make mental health care and assessment by qualified professionals (e.g. psychologists, GPs, psychiatrists) available to people residing in RACFs
- develop best practice guidelines/quality standards to improve the mental health and wellbeing of people living in RACFs, such as the quality standard used in the UK, the 'National Institute for Health and Care Excellence – Mental wellbeing of older people in care homes'.

## Voluntary Assisted Dying

Psychiatrists have specific skills and expertise to identify psychiatric illnesses and to assess suicidal ideation in patients, including the terminally ill. A person's capacity to make decisions may be affected by both mental and physical illness, including a treatable psychiatric condition.

Psychiatrists may have a role with patients who are considering or wish to discuss voluntary assisted dying (VAD) through the identification and treatment of mental illness and, when appropriate, making recommendations for patients' mental health treatment and care.

To help inform the VAD discussion, the RANZCP QLD Branch believes that the following issues should be considered:

- The rights of people with mental illness – the RANZCP QLD Branch does not believe that psychiatric illness should ever be the basis for VAD. We also consider that unrelievable psychiatric suffering is rare and that ensuring a person with mental illness has capacity in the VAD context may pose significant challenges.
- The rights of older people, including people with dementia – there is growing evidence to suggest that people who develop dementia under the age of 70 are at increased risk of suicide, especially if there are symptoms of depression and anxiety, meaning that they might, in some circumstances, consider VAD. We strongly support good quality assessment, care and support mechanisms for people with dementia.

- The right of medical practitioners to choose whether or not they wish to be involved in a VAD situation and the extent of their involvement, if any – 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 a potential VAD scenario.

## Issues Paper Questions

**Q25. Should voluntary assisted dying (VAD) be allowed in Queensland? Why/Why not?**

The RANZCP QLD Branch considers the primary role of medical practitioners in end-of-life care is to facilitate the provision of good quality patient-centred care, including at the final stages of their life. We recognise that VAD is a complicated ethical issue, and one that is best considered by the wider Queensland community. While the opinions of our members vary, a recent survey of RANZCP QLD Branch members indicates fairly strong support (73% of survey respondents) for the introduction of VAD under certain conditions – VAD being accessible to people over 18 years of age if they have a terminal illness, are experiencing intolerable suffering, and are in advanced state of decline, are close to death, and have decision-making capacity.

However, the RANZCP QLD Branch is concerned 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. Older people have a high rate of suicide internationally (Shah and Chatterjee, 2008), and may be more vulnerable to abuse under this legislation.

Furthermore, without adequate resourcing and accessibility of palliative care, the legalisation of VAD may present a perverse incentive for patients to choose to end their life, instead of being offered adequate palliative care. 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. However, the RANZCP QLD Branch considers that palliative care, aged care and in particular, dementia care, in Queensland is under-resourced. Palliative care physicians, geriatric medicine physicians and psychiatrists are all experiencing significant workforce shortages. 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.

The RANZCP QLD Branch would be concerned if the VAD scheme was funded at the expense of making improvements to other end-of-life care options for Queenslanders. All Queenslanders 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. Equitable access to care is particularly important for people residing in rural and regional locations.

**Q26. How should VAD be defined in Queensland? What should the definition include or exclude?**

Voluntary assisted dying would allow a person at the late stages of incurable, terminal disease to take a medication prescribed by a doctor that will end their life at a time and place they choose.

**Q27. If you are a health practitioner, what are your views on having a scheme in Queensland to allow VAD?**

Refer to answer to question 25.

**Q28. If there is to be a VAD scheme, what features should it have?**

Legal frameworks for VAD should be uncomplicated for medical practitioners and patients. Clear legislative and clinical guidelines should be developed and be made easily accessible, and processes need to be carefully regulated.

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 are making the decision freely and voluntarily. Therefore, both capacity assessment and undue influence screening should be required for every patient applying for VAD (Peisah et al., 2019).

Capacity assessments for VAD should:

- be conducted by medical practitioners (doctors) with specialty training in this area.
- include the provision of information about VAD and the alternative care options, to ensure that patients are making an informed decision.
- include screening for psychiatric disorders, and if present, trigger further psychiatric assessment with a psychiatrist.

Capacity assessments must be undertaken with great care, and may be best carried out by the patient's treating doctor. While psychiatrists have specialist skills in the area of capacity assessment, there would be significant practical barriers to psychiatrists carrying out assessments on all patients seeking access to VAD in a timely way, particularly for people in rural, remote and regional locations.

A psychiatric assessment should be undertaken with any patient with evidence of psychiatric illness, or an IDD who wishes to access VAD. Psychiatric assessment may also be warranted for patients whose decision-making capacity is in question.

When a specialist assessment is warranted, psychiatrists have specific skills and expertise to identify psychiatric illnesses and to assess suicidal ideation in patients, including the terminally ill. A person's capacity to make decisions may be affected by both mental and physical illness, including a treatable psychiatric condition. 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. It is important to note that impaired capacity can be temporary due to reversible, modifiable causes.

People living with dementia require special attention, with the question of competence to make decisions being of particular importance for this risk group. Support and training should be provided to medical practitioners who have not received psychiatry training to recognise diminished capacity, and refer patients for full psychiatric assessment. The clinical course of a person diagnosed with dementia may be highly variable, and can often be unpredictable. Patients with dementia frequently develop co-existing mood and anxiety symptoms, which are often responsive to appropriate treatment.

We suggest the Parliamentary Committee 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 a

substance for the purpose of causing death. The Victorian Act also requires a designated contact person to collect the medication from the pharmacy.

The RANZCP QLD Branch recommends the Queensland government develop transparent, accessible and easily understandable information on any VAD legislation and VAD process for members of the public and health practitioners. The Victorian government has published online clear and informative details of the Victorian VAD process and legislation (www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/voluntary-assisted-dying).

**Q29. Are there aspects of VAD schemes in other jurisdictions that should, or should not, form part of any potential VAD scheme for Queensland, and why?**

Ideally, Australian schemes should be nationally aligned to avoid confusion and over-burdening one state or territory with patients seeking services.

Given that Victoria is the first Australian state to introduce VAD, it would be sensible for the Queensland approach to align with the Victorian legislation. Victoria's *Voluntary Assisted Dying Act 2017* will be implemented from June 2019. Queensland will have the opportunity to monitor and review the implementation of the Victorian legislation before introducing legislation here.

We note that Victoria has established a Voluntary Assisted Dying Review Board to oversee voluntary assisted dying in Victoria. It will review every case of voluntary assisted dying in Victoria and make suggestions for changes or improvements in the law.

**Q30. Who should be eligible to access VAD and who should be excluded?**

People with a sole diagnosis of psychiatric illness should be excluded from accessing VAD. If terminally ill people have been affected by a psychiatric illness and subsequently receive treatment for that illness, they could later change their mind about their decision to end their life. The wish to die is not stable, especially if mental health problems are evident (Macleod, S 2012). However, as with the Victorian legislation, we recommend that people who meet all other criteria, and have a psychiatric illness, should not be denied access to VAD.

Advanced Care Directives (ACD) enable people to plan for their future medical treatment and care at a time when they are not competent to make, or unable to communicate, these decisions themselves. The RANZCP QLD Branch considers that ACDs should be excluded from VAD. Enacting an ACD can be difficult as people cannot always predict how they might feel in a particular situation. In addition, changes in service provision or technology may occur, thus altering the prognosis or the distress that the patient may otherwise experience.

**Q31. Should the scheme be limited to those aged 18 and over? If so, why? If not, why not?**

At this point, the RANZCP QLD Branch agrees that if VAD is introduced in Queensland, it should be limited to adults. There is increased difficulty determining capacity in younger people and children, made more complex by the need for parental consent.

**Q32. Under what circumstances should a person be eligible to access VAD? Could it be for example, but not limited to, the diagnosis of a terminal illness, pain and suffering that a person considers unbearable or another reason?**

The RANZCP QLD Branch considers it would be sensible to align criteria for VAD in Queensland, with that in Victoria, such that people must meet the following requirements:

1. The person must be diagnosed with a disease, illness or medical condition that:
    a. is incurable; and
    b. is advanced, progressive and will cause death; and
    c. is expected to cause death within weeks or months, not exceeding 6 months (or within 12 months for neurodegenerative diseases like motor neurone disease); and
    d. is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable.
2. The person must have the ability to make a decision about voluntary assisted dying throughout the process
3. The person must also:
    a. be an adult 18 years or over
    b. have been living in Queensland for at least 12 months

**Q33. What features should be included in a process to allow a person to legally access VAD?**

Refer to answers provided in questions 28-32.

**Q34. What safeguards would be required to protect vulnerable people from being coerced into accessing such a scheme and why?**

As described above, capacity assessments and undue influence screening must be mandatory for all applicants to ensure that the patient is independently making the decision to end their life. Access to good quality palliative care is also essential to ensure that the patient has viable alternatives to hastening their own death.

As mentioned above, older people have a high risk of suicide and suicide prevention programs must be extended to, and target, older Australians.

Any VAD scheme must stipulate a clear process and timeframes, incorporating safeguards such as input from more than one medical practitioner, the provision of information to the patient at different stages of the application, the requirement for a written declaration witnessed by independent people, a minimum time period between first and final request to prevent impulsive decisions, and the ability for the patient to withdraw the application at any stage.

A person's voluntary participation in the VAD process must be checked at all stages, including a final check of assent, similar to as occurs prior to undergoing anaesthesia to ensure people understand the implications of what they are going to do.

Specific training and clinical guidelines would need to be developed and provided for medical practitioners wishing to be involved in VAD. This should include screening tools for mental disorders and neuropsychiatric conditions, and identifying other risk factors for vulnerable populations such as older, isolated women.

As psychiatrists have expertise in capacity assessments and psychiatric assessments, we recommend that psychiatrists be involved in the development of any VAD training materials and clinical guidelines for medical practitioners. The RANZCP QLD Branch would welcome the opportunity to assist in this process.

As with similar schemes in other jurisdictions, any VAD scheme will need to be carefully regulated and monitored to ensure compliance with the law, and systematically reviewed on a regular basis. For example, the Victorian Voluntary Assisted Dying Review Board that will oversee the scheme.

**Q35. Should people be provided access to counselling services if they are considering VAD? If so, should such counselling be compulsory? Why?**

The RANZCP QLD Branch considers that counselling should be offered to all patients considering or embarking upon VAD, but not mandated. As raised above, capacity assessment and undue influence screening should be compulsory for all VAD applicants, with further psychiatric assessment required under some circumstances. If a patient has demonstrated capacity and no undue influence is detected, counselling should not be compulsory as it would undermine their autonomy.

For those patients who wish to access counselling, it should be affordable and easily accessible, at every stage along the process. It should be unbiased and provided by an appropriately qualified person.

**Q36. How could a VAD scheme be designed to minimise the suffering and distress of a person and their loved one?**

Patients considering VAD should be able to access clear information about the requirements, how to navigate the process, who can assist and the expected timeframes. For example, the Victorian government has provided a community and consumer information sheet on understanding VAD.

It is important that the necessary infrastructure and resources are in place prior to the commencement of VAD in Queensland, including an adequate number of trained medical practitioners to undertake capacity assessments and prescribe the medication, and other support services for the patient and their carers throughout the process. This will ensure patients can access VAD when they are ready, and not suffer with unnecessary delays.

**Q37. Should medical practitioners be allowed to hold a conscientious objection against VAD? If so, why? If not, why not?**

Medical practitioners have a right to choose whether they wish to be involved in a VAD situation and the extent of their involvement, if any. Psychiatrists may not wish to take on a ‘gatekeeper’ role in a potential VAD application.

The survey of RANZCP QLD Branch members showed that there was reluctance or uncertainty amongst 42% of respondents as to whether they would personally be prepared to assess capacity in a request for VAD. Research amongst British psychiatrists shows that while 64% agree that psychiatric assessments are important in this context, only 35% would be willing to carry out such assessments (Shah et al., 1998)

Any proposed legislation must provide medical practitioners with the option of holding a conscientious objection to being involved in VAD.

**Q38. If practitioners hold a conscientious objection to VAD, should they be legally required to refer a patient to a practitioner that they know does not hold a conscientious objection or to a service provider that offer such a service? If so why? If not, why not?**

Professional ethics entitle a doctor to their own opinion but do not permit the doctor to promote these viewpoints to their patient. However, if a doctor finds themselves unable to treat patients because of their personal moral values, they should be allowed to exclude themselves from treating the patient but have a duty to refer the patient so that they can receive appropriate care and treatment elsewhere.

The RANZCP QLD Branch supports the recognition of conscientious objection by registered health practitioners, alongside a requirement to refer a patient to another appropriate medical practitioner.

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