Submission to

the Royal Commission into Victoria's Mental Health System

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This submission addresses new risks for Victorians with mental health issues that will arise from the coming into operation of the *Voluntary Assisted Dying Act 2017* on 19 June 2019.

The Australian Care Alliance was formed in March 2018 by health professionals, lawyers and community activists who had worked together informally to oppose the passage of the *Voluntary Assisted Dying Bill 2017* through the Parliament of Victoria.

It is the considered position of the Australian Care Alliance, based on all the available evidence, that none of the jurisdictions that have legalised euthanasia and/or assisted suicide have succeeded in establishing a safe and compassionate framework for assisted suicide and euthanasia.

The Alliance has identified eleven categories of wrongful deaths that have or can occur under any scheme so far proposed which legalises assisted suicide and/or euthanasia.

These categories of wrongful death include two categories of direct relevance to the Royal Commission:

- The wrongful death of persons with mental illness;
- The wrongful death of persons with suicidal ideation arising from or exacerbated by suicide contagion from the State sanctioning of assisted suicide as a valid choice for some Victorians and an abandonment of the public policy of suicide prevention for all Victorians.

Mental illness and the Voluntary Assisted Dying Act 2017

Section 9 (2) of the Voluntary Assisted Dying Act 2017 ("the Victorian Act") provides that:

A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness, within the meaning of the ***Mental Health Act 2014****.*

The force of the word "only" is the key to understanding the limited usefulness of this provision in protecting persons with mental illness from the risk of a wrongful death by assisted suicide or euthanasia.

This provision does not preclude a person with a profound mental illness but who also has another "*disease, illness or medical condition"* that meets the criterion set out in section 9 (1) (d) of the Act from accessing assisted suicide or euthanasia.

Nor does it explicitly preclude a mental illness from itself being considered to be "*a disease, illness or medical condition"* that meets the criterion set out in section 9 (1) (d) of the Act. For example, a person with anorexia who is expected to die within 6 months as a result of refusing treatment could qualify. Even a person with treatment resistant suicidal ideation may assessed by some doctors as likely to die from this illness within 6 months.

In Belgium between 2014 and 2017 there were 201 cases of euthanasia for mental and behavioural disorders. Of these 14 were cases where death was expected in the short term ('*breve*') as a result of the mental illness and so could potentially have also qualified under the Victorian law.[1]

In the Netherlands, court decisions had upheld the legality of euthanasia for anorexia since 1991[2] and for treatment resistant suicidal ideation since 1993[3], well before formal legalisation.

It remains to be seen whether the Victorian Act will be applied in this way.

Assessing decision-making capacity for assisted suicide: the Oregon experience

Sections 18 (1) and 27 (1) of the Victorian Act provide respectively that if the co-ordinating medical practitioner or the consulting medical practitioner:

> *is unable to determine whether the person has decision-making capacity in relation to voluntary assisted dying as required by the eligibility criteria, for example, due to a past or current mental illness of the person, [he or she] must refer the person to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of mental illness.*

[1] Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie, *Huitième rapport aux Chambres législatives années 2016 – 2017*, p.20 – graphique 10, https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/8_rapport-euthanasie_2016-2017-fr.pdf

[2] District Court of Almelo, 20 December 1991: NJ 1992, 210; Tijdschrift voor Gezondheidsrecht 1992/19

[3] High Court of the Hague, 25 May 1993: Tidschrift voor Gezondheidsrecht 1993/52; Medisch Contact 48 (1994) 1377-1381

It is entirely up to the assessing doctors to form their own view as to their expertise in assessing decision-making capacity.

This provision is weaker than the corresponding provision in Oregon which refers to "*impaired judgement*"[4] rather than a lack of "*decision-making capacity*" which is defined in section 4 of the Victorian Act in purely cognitive terms, taking no account of the effects, say, of depression or demoralisation on a person judging what is truly in his or her best interests.

Oregon's *Death With Dignity Act*, which has been operative since 1997, provides for medical practitioners to provide prescriptions for lethal medications to be taken later by the person for whom the lethal dose is prescribed.

Research by Linda Ganzini et al. found that "*Among terminally ill Oregonians who participated in our study and received a prescription for a lethal drug, one in six had clinical depression*".[5]

However, in 2018 only 3 out of 168 people (1.78%) who died under the Oregon law were referred by the prescribing doctor for a psychiatric evaluation before writing a script for a lethal substance.[6] This means it is likely that – in one year alone - about 25 people with clinical depression were prescribed and took a lethal poison without being referred for a psychiatric evaluation.

In 2011 Dr. Charles J. Bentz of the Division of General Medicine and Geriatrics at Oregon Health & Sciences University explained that Oregon's physician-assisted suicide law is not working well. He cited the example of a 76-year-old patient he referred to a cancer specialist for evaluation and therapy. The patient was a keen hiker and as he underwent therapy, he became depressed partly because he was less able to engage in hiking.

He expressed a wish for assisted suicide to the cancer specialist, who rather than making any effort to deal with the patient's depression, proceeded to act on this request by asking Dr Bentz to be the second concurring physician to the patient's request.

When Dr Bentz declined and proposed that instead the patient's depression should be addressed the cancer specialist simply found a more compliant doctor for a second opinion.

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[4] Oregon Death With Dignity Act, Oregon Revised Statutes, 127.825 §3.03., https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/statute.pdf

[5] Linda Ganzini et al., "Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey", *British Medical Journal*, 2008;337:a1682 https://www.bmj.com/content/bmj/337/bmj.a1682.full.pdf

[6] Oregon Public Health Division, *Oregon Death With Dignity Act: 2018 Data Summary, Table 1,* p.11 https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year21.pdf

Two weeks later the patient was dead from a lethal overdose prescribed under the Act.

Dr Bentz concludes;

"*In most jurisdictions, suicidal ideation is interpreted as a cry for help. In Oregon, the only help my patient got was a lethal prescription intended to kill him.*" He urges other jurisdictions "*Don't make Oregon's mistake*."[7]

Under section 36 of the Victorian Act the two people witnessing the signature on the written declaration must certify in writing "*that, at the time the person signed the declaration, the person appeared to have decision-making capacity in relation to voluntary assisted dying*". This hardly adds any extra assurance to the process as the witnesses do not need to have any expertise or prior knowledge of the person.

There is a provision in section 68 of the Act for a person who is considered by VCAT (Victorian Civil and administrative Tribunal) to have "*a special interest in the medical treatment and care of the person*" assessed as eligible for assisted suicide or euthanasia to apply to VCAT for a review of the decision that the person has decision-making capacity. However, this is of limited help in protecting persons with mental illness as not all of those at risk will have a relevant family member or other person who identifies the problem and who has the knowledge and determination to initiate an action at VCAT.

Should suicide prevention strategies include all Victorians?

The Commission asks (Question 3):

What is already working well and what can be done better to prevent suicide?

From 19 June 2019 all those Victorians who are assessed by two doctors as eligible for assisted suicide under the provisions of the *Voluntary Assisted Dying Act 2017* will, simply because of that fact, effectively be excluded from the otherwise universal public policy of suicide prevention for all Victorians.

This exclusion necessarily implies that the State of Victoria believes that these Victorians would be better off dead and supports their suicide as a legitimate, rational choice to be facilitated rather than prevented.

Indeed the State will issue a formal permit authorising the prescription of a lethal substance for the purpose of the person's suicide as well as pay for and supply – including delivery throughout Victoria - the lethal substance.

[7] http://blogs.theprovince.com/2011/12/05/province-letters-icbc-egypt-assisted-suicide-oregon-christmas-pre-marital-sex/

The question arises as to how publicly and openly offering assistance, including financial assistance, to commit suicide to one group of Victorians Australians fits with the public policy goal, widely shared across the whole community, to reduce the incidence of suicide?

Does legalising assisted suicide reduce the suicide rate as claimed?

Proponents of assisted suicide have claimed that providing the elderly, terminally ill with a legal lethal dose of drugs to facilitate assisted suicide will reduce the incidence of other forms of suicide among this group and, because, it is claimed, many of those for whom the lethal dose is prescribed may never take it, actually decrease the overall suicide rate.

This hypothesis has been subjected to careful scrutiny in an important study by David Albert Jones and David Paton comparing trends in suicide rates in those states of the United States which have legalised assisted suicide compared to those which have not.[8]

The study, which controlled for various socio-economic factors, unobservable state- and year effects, and state-specific linear trends, found that legalizing assisted suicide was associated with a 6.3% increase in total suicides (i.e. including assisted suicides).

This effect was significantly larger in the over 65 year old age group with a massive 14.5% increase in total suicides.

The introduction of legalised assisted suicide was not associated with a reduction in non-assisted suicide rates, nor with an increase in the mean age of non-assisted suicide.

The conclusion is that assisted suicide either does not inhibit (nor acts as an alternative to) non-assisted suicide, or that it acts in this way in some individuals but is associated with an increased inclination to suicide in other individuals.

The latter suggestion would be consistent with the well known Werther effect of suicide contagion[9] most recently confirmed in a study demonstrating an increase in youth suicides following the screening of a television series called *13 Reasons Why*.[10]

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[8] https://pdfs.semanticscholar.org/6df3/55333ceecc41b361da6dc996d90a17b96e9c.pdf

[9] http://journals.sagepub.com/doi/abs/10.1080/00048670701266680

[10] Jeffrey A Bridge et al., "Association Between the Release of Netflix's *13 Reasons Why* and Suicide Rates in the United States: An Interrupted Times Series Analysis", Journal of the American Academy of Child & Adolescent Psychiatry, Article in press, Accepted manuscript available (as at 2 May 2019) at:

https://issuu.com/thecolumbusdispatch/docs/association_between_the_release_of_

Effect on families

Suicide is a distressing event that disrupts the lives of families, friends and communities who are bereaved. Like any other suicide, assisted suicide can profoundly affect surviving family members and friends.

A 2010 study found that about 20% of family members or friends who witnessed an assisted suicide in Switzerland, where assisted suicide is legal, subsequently suffered from full (13%) post-traumatic stress disorder or subthreshold (6.5%) post-traumatic stress disorder. [11]

Conclusion on assisted suicide and suicide prevention

The provisions of the *Voluntary Assisted Dying Act 2017*, which allow State approved, funded and facilitated suicide of some Victorians, create an unacceptable risk of undermining efforts to prevent suicide for all other Victorians and of increasing the trauma suffered by families, friends and communities due to the suicide of loved ones.

Recommendation:

1. Due to the unacceptable risk it poses to persons with mental illness or with suicidal ideation of wrongful death from assisted suicide the *Voluntary Assisted Dying Act 2017* should be repealed.

2. Persons diagnosed with a terminal illness should be considered as a group at risk of suicide and the health care workforce be better trained to identify clinical depression and demoralisation in such persons and to provide appropriate psychiatric treatment and care.

[11] B. Wagner et al, "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide", *European Psychiatry*, Volume 27, Issue 7, 542 – 546, https://linkinghub.elsevier.com/retrieve/pii/S0924933810002683