Ref: NG/BM: OCP10630
Enquiries: Dr Nathan Gibson

Dr Jeannine Purdy
Principal Research Officer
Joint Select Committee on End of Life Choices
Legislative Assembly
Parliament House
Perth WA 6000

Via email: eolcc@parliament.wa.gov.au

Dear Dr Purdy

RE: SELECT COMMITTEE ON END OF LIFE CHOICES

Thank-you for the opportunity to provide feedback to this debate.

The Chief Psychiatrist, under section 515 of the *Mental Health Act 2014,* has responsibility for treatment and care of; all voluntary patients by a mental health service, all involuntary patients, all mentally impaired accused required under the MIA Act to be detained at an authorised hospital, all persons referred under section 26(2) or (3)(a) or 36(2) for an examination to be conducted by a psychiatrist at an authorised hospital or other place, and all persons on an order made under section 55(1)(c) or 61(1)(c) to enable an examination to be conducted by a psychiatrist at an authorised hospital.

The Chief Psychiatrist must discharge that responsibility by publishing under section 547(2) standards for the treatment and care to be provided by mental health services to the persons referred to above and overseeing compliance with those standards. The standards of end of life care for those individuals who fall within this remit are then very much the remit of the Chief Psychiatrist's role.

While I do not speak for the Binational Royal Australian and New Zealand College of Psychiatrists (RANZCP) or the RANZCP WA Branch (notwithstanding I am Fellow of the RANZCP), I have been made aware of key elements of the submission prepared by the RANZCP WA Branch for the Select Committee on End of Life Choices. I would seek the Select Committee give due consideration to that submission.

I also note the **RANZCP 2016 Position Statement on Physician Assisted Suicide** and would request the Select Committee also give due consideration to that position statement.

From the perspective of the role of the Chief Psychiatrist, I am not seeking to undertake a broad ranging discussion but to focus on key issues for individuals with severe, enduring or complex mental illness.

I am also not seeking to take a broad specific philosophical or moral position on end of life choices, but wish to highlight the importance of rigorous assessment for mental illness, the significant vulnerability of individuals with mental illness, and the complexity of clarifying the relative motivations for an individual with mental illness who wishes to die.

I am seeking to advocate for robust standards of clinical care and have individuals with mental illness excluded from any potential legislation regarding voluntary assisted dying.

An individual with severe, enduring or complex mental illness may develop a terminal illness. In fact, following world-leading research by Prof David Lawrence and others in WA, it is noted that individuals under the care of mental health services are likely to die 12-15 years earlier than the general population, primarily because of cardiovascular disease and cancer and *not* predominantly due to suicide. Individuals with psychotic illness such as schizophrenia die, on average, 23 years earlier again, with physical health causes predominating. This in itself is a public health travesty. While individuals with mental illness who develop a terminal illness must be afforded the same rights as the general population regarding end of life, the debate is more complex than this statement alone.

The issues are:
1. Mental Health stigma
2. The nature of mental illness
3. Capacity
4. Implicit vulnerability
5. An individual with mental illness who develops a terminal illness

<u>Mental Health Stigma</u>

Professor Norman Sartorius, one of the lead authors of the ICD-10 International Classification of Mental and Behavioural Disorders notes that stigma is the greatest barrier to accessing treatment for mental illness.

Corrigan and Watson in 2002 described the components of stigma as stereotyping, prejudice and then discrimination. There is evidence that clinicians still stigmatise and individuals with mental illness still stigmatise themselves. Stigma influences how individuals and families with mental illness present themselves and deal with the world.

There are significant overt and covert stereotyping, prejudices and discrimination against individuals with mental illness embedded into contemporary Australian society.

Stigma may play an overt or covert role in an individual with mental illness seeking to end their life.

The Nature of Mental Illness

Mental illnesses and disorders are not one entity. There is a range of mental health disorders with significant and distressing functional impairment, and where there are varying complex biological, psychological and social determinants of, and interface with, the illness. It's never a matter of being all biological or all socially determined- it's a mix and the components of that mix will vary from individual to individual.

To try to oversimplify this does not allow proper understanding of the individual and family's/carer's difficulties, and does not adequately address the treatment, care and support needs of the individuals with the disorders or those who support them. Mental illnesses are generally not terminal illnesses, although disorders such as the Dementias (eg Alzheimer's Disease) are terminal illnesses.

While there are robust, internationally-recognised classifications systems, including the ICD-10 and the Diagnostic and Statistical Manual Version 5 (DSM 5), the diagnosis of mental illness still requires an expert clinician to assess for the criteria. While the classification systems seek to objectify this process as far as possible, the assessment of criteria for mental illness will still have components of subjective weighting and analysis based on the skill and experience level of the individual clinician. It is not uncommon for clinicians to disagree on the nature of an individual's mental illness.

Despair, hopelessness and traumatisation are not uncommon remediable components of mental illness.

Thus, the considered prognosis for mental illness may be variable, depending on the clinician skillset in assessment, and the access to treatments.

Serious disorders such as Schizophrenia, Eating Disorders and Borderline Personality Disorders have increased mortality due to the disorders themselves. But they are not inherently terminal illnesses, and should not be viewed in the same way as terminal physical illnesses.

Mental illnesses are generally not terminal illnesses.

There is good reason to take a more optimistic view of longer term outcomes of mental illness.

There is good reason to believe that individuals with mental illness can lead a meaningful, contributing life.

Capacity

Part 5 of the *Mental Health Act 2014* defines the process for capacity and informed consent. While capacity is a legal decision, it is important to note that:

- Capacity is decision-specific

- Capacity is fluctuant, and can change over time
- The assessment of capacity in a clinical setting cannot be a "tick-box", but involves a robust interpersonal assessment as well as consideration of the specific criteria
- Ability to assess capacity is a variable skill across medical practitioners
- Where an individual has significant, fluctuating mental illness, the clarification of decision-making capacity can be a significant ongoing challenge

Capacity is complex in individuals with mental illness.

Implicit vulnerability

Given the complexity of considering human rights in the situation of an individual with serious mental illness (e.g. right to choose, right to treatment, rights of others impacted by the illness, etc), end of life decisions must demonstrate robust and documented diligence in the clarification of the presence or absence of mental illness.

While individuals with mental illness must be afforded the same rights as other individuals within society, they are implicitly vulnerable in the potential context of seeking end of life because of issues of stigma, the inherent nature of mental illness (the complexity of determining remediable drivers and the influences on these), and the complexity of determining capacity.

It is inherently complex to determine the influences on drivers to seek end of life in an individual with mental illness.

It cannot be assumed that decision making regarding end of life for an individual with mental illness is linear, simple or obvious.

An individual with mental illness who develops a terminal illness

If a person has capacity or if they made an Advanced Health Directive when they had capacity, they should not have different rights from other people because of their mental illness. The rigorous process to clarify capacity and assertively treat the mental illness must be vetted.

Recommendations

1. I recommend that mental illness as the reason itself be an absolute exclusion category for voluntary assisted dying if legislation is considered by the WA Parliament.

2. I recommend that any assessment for the potential existence of mental illness in an end of life decision:

    a. Be mandatory
    b. Be multiphasic
    c. Be undertaken over a period of time
    d. Require extensive third-party corroboration

e. Be subject to assessment by multiple credentialed practitioners in any single, individual case
f. Be vetted, to exclude inadequate treatment, support or carer resourcing

I am happy to discuss further should it be required. I may be contacted on

Yours sincerely

Dr Nathan Gibson
CHIEF PSYCHIATRIST

24 October 2017