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Select Committee on End of Life Choices
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To the Principal Research Officer

Inquiry into the need for laws in Western Australia to allow citizens to make informed decisions regarding their own end of life choices

The Australian Psychological Society (APS) welcomes the opportunity to make a submission to this Inquiry about end of life choices in Western Australia. The significance of end of life issues for the APS was demonstrated by a roundtable convened on 13 October 2017. Psychologists have much to offer people and their families at the end of life, and this event was organised to identify the implications of any legislative changes as well as assist the APS to develop resources to better equip psychologists to work in this space.

The APS has made several relevant submissions to State and Federal Government Inquiries over the last few years:

- [Victorian Government Voluntary Assisted Dying Bill Discussion Paper](#) – April 2017
- [Victorian Parliamentary Inquiry into End of Life Choices](#) – July 2015
- [Senate Inquiry into the exposure draft of the Medical Services \(Dying with Dignity\) Bill](#) – August 2014

We also draw the Inquiry's attention to the most recent issue of the Australian Psychologist, [Vol. 52, No. 5 Special issue: Psychology and End of Life](#), edited by Lauren J. Breen and Anna Ugalde.

This submission will not address the specific Terms of Reference, but rather offer a response regarding the broader context around the need for laws to allow citizens to make informed decisions about end of life choices.

The APS is the national professional organisation for psychologists, with more than 22,500 members across Australia. Psychologists are experts in human behaviour and bring experience in understanding crucial components necessary to support people to optimise their function in the community.

APS members are required to abide by the ethical standards set out in its [Code of Ethics](#), which has been adopted and endorsed by the Psychologists Registration Board of Australia. The *Code* is built on three general ethical principles: Respect for the rights and dignity of people and peoples; Propriety; and Integrity, all of which are relevant to this Inquiry as well as for psychologists involved in end of life care. For example, respect for a person's rights and dignity could be seen to support their inalienable right to life, or conversely their right to request a dignified end to that life. Similarly the general principle, Propriety, incorporates the principle of non-maleficence ('do no harm'), which can be interpreted to forbid the hastening of death, or to support active intervention in a situation intolerable to the patient.

While the APS neither opposes nor endorses voluntary termination of life, changes to legislation are likely to impact on the work of psychologists, particularly if there is provision for psychologists to undertake mental health and/or decision making capacity assessments. Also of concern to the APS is the impact of legislative change on the health and wellbeing of people in later life, their friends and family, and the broader community.

The APS endorses a best practice approach to end of life care, requiring that the patient fully understands his/her alternatives and the main ramifications of his/her decision to access assisted dying services should they become legal. Ultimately, the APS emphasises the importance of a process that is characterised by care, compassion and considered decision-making over time (Maddocks, 2014). The APS envisages that such a process would include access to the full range of care options, from the highest quality palliative care and the most competent psychological assessment and psychosocial support.

The APS acknowledges that dealing with issues surrounding the choice of a terminally ill person to request assistance from a medically qualified person to voluntarily terminate his or her life humanely is complex and challenging. This issue needs to be examined from a number of perspectives that encompass psychological, ethical/moral, medical, legal, religious, sociological and political considerations.

In addition to physical health, end of life concerns encompass individual and shared community perceptions of what a life worth living looks like, and enabling people create their own possibilities, hope and choices. In the Western world, people are living longer and death is becoming less visible and more medicalised. There is a growing movement to challenge the silence around these concerns, and to facilitate conversations and communication about death and dying (Bartel, 2016).

The APS believes psychologists can and should be involved in end of life issues in a variety of ways including: facilitating conversations and addressing the stigma

around death and dying, contributing to policy development and best practice for the care of the terminally ill, involvement in the process of support and decision-making for family as well as the patient (including decisions about assisted dying should it become legal), the assessment of psychological disorders and mental competence, and the treatment and management of mental health problems associated with end of life.

Psychologists also have a role in facilitating supportive conversations to enable people to carefully consider their options and plan for their future – encouraging people to complete appropriate documentation, identify a guardian and an enduring power of attorney and think about advance care planning and advance care directives (living wills). Further tasks include educating other professionals, and contributing professional skills and perspectives to multi-professional teams.

The adequacy of health care is likely to play an important role in a person's decision-making, such that a request for assisted dying may follow a failure of one or more parts of the health system to provide adequate care. Such requests may be made in the context of serious social inequities in access to resources such as basic medical care (APA Resolution on Assisted Dying and Justification, 2017). While Australians are increasingly wealthy on average, there is also rising inequality. Inequality leads to poorer health outcomes and higher levels of suicide, particularly amongst people within disadvantaged groups. We can improve how people die by improving training to create a better health workforce, creating better infrastructure, and having more appropriate policies and protocols in place to maximise the real choices available to the seriously and terminally ill.

Palliative care is the most established end of life model of care; however its capacity to prevent/alleviate severe suffering (including pain control and refractory symptoms) is not absolute, and it is not always available to all people who might benefit, or equally accessible to diverse community groups (such as residents of aged care facilities, people who have terminal illnesses other than cancer, people living in rural and remote communities, and people from Indigenous and culturally and linguistically diverse backgrounds). Furthermore, this model of care is not acceptable to a significant minority of dying people.

It is important to understand how mental illness (e.g. severe depression) affects competence and advance care planning. In many cases (e.g. early stages of Alzheimers), people are competent to undergo advance care planning. While psychologists can play a key part in diagnosis of mental disorders and assessment of competence, a diagnosis of clinical depression or cognitive impairment should not automatically negate a person's right to access care choices available to other patients.

The APS presented evidence at the associated hearing of the Senate Inquiry into the Medical Services (Dying with Dignity) Bill in October 2014. We invite the Committee to read the Hansard transcript as well as the [submission](#) itself, as these documents explain the key concerns of the APS. In summary, the APS noted that the model proposed under the Bill was very medically oriented and did not consider the broader psychological and psychiatric dimensions of introducing this option into the death trajectory. The critical element of “mental competence” being a threshold for access to dying with dignity services was noted as problematic, and thus the APS submission highlighted the need for a holistic assessment (not just medical assessment). The APS was also concerned about the need to acknowledge and incorporate family, cultural and gendered perspectives into the debate.

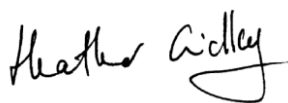
In addition, the APS Discussion Paper [Psychological Perspectives on Euthanasia and the Terminally Ill](#), updated in 2008, addresses a number of issues relevant to this Inquiry. The Paper noted that there exists:

an inherent tension between respecting individual autonomy and relieving people from unbearable suffering while still protecting the principle of valuing human life. Any liberalising of laws in relation to euthanasia needs to achieve a satisfactory mechanism which balances this tension, achieves respect for individual rights (of patients, carers and professional health workers), and prevents abuse, without becoming too unwieldy, bureaucratic and time consuming to be practical (p. 21).

The APS takes a similar position to that of the [American Psychological Society](#) (APA), which neither endorses nor opposes assisted dying given the complex multitude of issues involved. In their recent [Resolution on Palliative Care and End-of-life Issues](#), the APA also advocates for quality end of life care for all individuals; promotes research on assisted dying; promotes policies that reduce suffering; and supports research on ethical dilemmas faced by clinicians and researchers. Both the APS and APA statements foreground the need to protect first and foremost the wellbeing of the individual concerned. Consideration should also be given to the needs of family members and professionals involved.

We would be pleased to assist you further. For further information please contact me on 03 8662 3327.

Yours sincerely,



Ms Heather Gridley FAPS
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