

27 November 2020

The Secretary
Queensland Law Reform Commission
PO Box 13312
George Street Post Shop
Qld 4003

Level 13, 257 Collins Street
Melbourne VIC 3000
PO Box 38
Flinders Lane VIC 8009
T: (03) 8662 3300
F: (03) 9663 6177
psychology.org.au

Via Email: lawreform.commission@justice.qld.gov.au

Dear Secretary,

Submission to the Consultation Paper WP No. 79: A legal framework for voluntary assisted dying

The Australian Psychological Society (APS) welcomes the invitation to provide a submission in response to the Queensland Law Reform Commission's Consultation Paper about a legal framework for voluntary assisted dying.

The APS is the peak professional body for psychology in Australia, representing over 25,000 members nationally. A key goal of the APS is to actively contribute psychological knowledge for the promotion and enhancement of community wellbeing. The APS regularly consults with psychologists, consumers of psychological services, communities and organisations, to best understand the psychological needs of the Australian population and to identify and address the individual, family and systemic issues that contribute to social problems, and to find better ways of addressing such problems.

The submission that follows is based on feedback sought from our members.

The APS has made many submissions relating to voluntary assisted dying which can be found on the [end-of-life advocacy](#) section of our website. Most relevant to this inquiry is:

- the [APS Submission to the Queensland Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying](#); and
- the [APS response to the Discussion Paper on the Victorian Government Voluntary Assisted Dying Bill](#) (2017).

If the Commission requires further APS input, I may be contacted through my office on (03) 8662 3300 or by email at z.burgess@psychology.org.au.

Yours sincerely

Zena Burgess FAPS FAICD
Chief Executive Officer

APS Submission to the Consultation Paper WP No. 79: A legal framework for voluntary assisted dying

The APS supports a compassionate and safe assisted dying framework, whereby voluntary assisted dying is available as part of a full range of care options, including the highest quality palliative care and the most competent psychological assessment and psychosocial support. The APS endorses a best practice approach to end-of-life care, wherein the person fully understands the alternatives and the main ramifications of their decisions. Ultimately, the APS emphasises the importance of a process that is characterised by care, compassion and considered decision-making over time.

As stated in the [APS submission to the Queensland Inquiry](#), with the introduction of voluntary assisted dying the APS strongly advocates for increased access to psychological services to assist in:

1. Decision-making capacity assessment
2. Therapeutic interventions for patients and their families
3. Clinical supervision for the service/s delivering assisted dying services.

The main risks and issues of voluntary assisted dying legislation from a psychological perspective that have been explored in detail in previous submissions include:

- competence and decision-making capacity and the intersections with mental illness and cognitive impairment;
- coercion and the impact of family and societal attitudes;
- managing the process for conscientious objection;
- the impact on practitioners working with people approaching the end of life;
- increased access to psychological services to assist in capacity assessments, therapeutic interventions and clinical supervision;
- the adequacy and access to health care; and
- the need for more investment in palliative care.

In general, the APS believes that it would be good to keep the Queensland Act consistent with the legislation in other States to avoid confusion and help streamline the training of professionals. However, it is also acknowledged that the implementation of voluntary assisted dying in one jurisdiction (e.g. Victoria) can be a source of great insight and the challenges that emerge may reveal important lessons for other jurisdictions.

In this submission, the APS will draw on insights from psychological science and practice to respond to the most relevant questions and proposals.

Q-6 Should the eligibility criteria for a person to access voluntary assisted dying expressly state that a person is not eligible only because they: (a) have a disability; or (b) are diagnosed with a mental illness?

The APS believes that the Queensland legislation should be consistent with Victorian (VIC) and Western Australian (WA) legislation which “expressly provides that a person is not eligible to access voluntary assisted dying only because they are diagnosed with a mental illness, or because they have a disability.” (Section 4.19)

P-2 The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must be acting voluntarily and without coercion.

Yes. The APS agrees that a person must be acting voluntarily and without coercion to be eligible for access to assisted dying.

In the VIC and WA legislation there is no mention of undue influence or voluntariness in the definition of capacity and the mention of decisions having to be made voluntarily and without coercion is included elsewhere in the legislation. Therefore, the Queensland legislation should additionally provide that the person is acting voluntarily (rather than saying it is intrinsic to having decision-making capacity).

Decisions are influenced by a range of factors, including the opinions of others, notably family members, carers and health professionals. As such, strategies to minimise the risk of coercion, e.g. enabling people to make decisions in private, may be appropriate. It is worth noting here that demonstrating an understanding of the consequences of their decisions, and making those decisions freely without undue influence, are components assessed as part of decision-making capacity. This also highlights the importance of professional standards and training for medical practitioners in order to minimise the likelihood of coercion when working with individuals who may request voluntary assisted dying.

Also of relevance is the indirect coercion potentially experienced as a result of living in a society that regards many vulnerable people (e.g. older people and people with a disability) as a burden. Decisions about assisted dying are often made in the context of serious social inequities in access to resources such as basic medical care, thus it is vital that access and support should be provided when a request is made (with particular attention to people living in rural and remote areas), including a referral to another practitioner where appropriate. This is also why the APS recommends that any future legislation include an equity impact assessment (a decision support tool designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people) (see [APS submission to the Queensland Inquiry](#)).

A better quality, more accessible, service system should be the priority. Not only is it likely to reduce the demand for assisted dying services, at the same time, a strong service system is likely to avoid any abuses and ensure it works well.

P-3 The draft legislation should provide that, for a person to be eligible for access to voluntary assisted dying, the person must have decision-making capacity in relation to voluntary assisted dying.

Yes. The APS supports the proposal that a person must have decision-making capacity in relation to voluntary assisted dying, in alignment with legislation in VIC and WA.

This necessitates that the process of how such conclusions as to an individuals' capacity (or lack thereof) are determined need to be specified and documented for each individual.

This will assist in ensuring a due and thorough process that mitigates against coercion and upholds the voluntary principles.

Q-7 Should the eligibility criteria for a person to access voluntary assisted dying require that the person must be diagnosed with a disease, illness or medical condition that is expected to cause death within a specific timeframe?

The APS understands that the current Queensland Parliamentary Committee recommendation is that no timeframe be proposed (Section 4.40), which differs to the VIC and WA legislation. This is a complex area, and the APS understands the arguments for not imposing a timeframe (e.g. people should be free to choose the timing and it shouldn't be determined by disease type). However, in the interests of having national consistency on such a sensitive issue and minimising a form of geographic discrimination, the APS recommends that the timeframes align as much as possible with VIC and WA legislation.

In Victoria, the timeframe imposed was considered to be consistent with current healthcare practice and the end-of-life and palliative care framework in Australia. Namely, this refers to the '[National consensus statement: essential elements for safe and high-quality end-of-life care](#)' which considers the elements within the statement to be applicable within a 12-month period towards end-of-life.

Q-12 Should 'decision-making capacity' be defined in the same terms as the definition of 'capacity' in the Guardianship and Administration Act 2000 and the Powers of Attorney Act 1998, or in similar terms to the definitions of 'decision-making capacity' in the voluntary assisted dying legislation in Victoria and Western Australia? Why or why not?

The APS can understand the attraction of having a common definition in relation to 'capacity' across all relevant legislation in Queensland (e.g. people likely to be involved in the decision-making process are familiar with the process and there are standardised tests available). However, the decision required for voluntary assisted dying is unique, very specific and the consequences are ultimately irreversible. There should be a clear definition of capacity that is ideally consistent with the definitions in VIC and WA. This is important from a training perspective.

High quality training is absolutely essential. Furthermore, any training modules for medical practitioners or other relevant professionals should be informed by those who have skills and experience in conducting capacity assessment in complex matters (as mentioned below in section 23(a)), as was the case for the VIC training modules.

From a professional perspective, the APS would value and support the development of a well-structured assessment process that psychologists can use and it is advisable that this process is consistent across the country to make both professional training and research easier to implement.

Q-23 Should the draft legislation provide that, if the coordinating practitioner or consulting practitioner:

(a) is not able to determine if the person has decision-making capacity in relation to voluntary assisted dying—they must refer the person to a health practitioner with appropriate skills and training to make a determination in relation to the matter (as in Victoria and Western Australia);

Yes. Referral to an appropriate health practitioner should be required. However, this may only be possible by upskilling the workforce, particularly in regional and remote areas, to ensure that all people can access suitably trained and experienced practitioners, face-to-face and in a timely manner.

Furthermore, when people are referred to a suitable health practitioner, people with a disability or mental illness should be provided with appropriate support to make decisions as required.

As expressed in the [APS submission to the Queensland Inquiry](#), the focus of capacity assessment is not on whether the decision to die is sensible, right, or wrong; but in fact whether the person can demonstrate an appreciation of their current circumstances and then apply that understanding to make decisions in alignment with their preferences and values. Demonstrating an understanding of the consequences of their decisions, and making those decisions freely without undue influence, are also components assessed as part of decision-making capacity. It is also important to acknowledge and account for the fact that decisions can change, and that variations over time are not to be confused with ambivalence, and should not be used to undermine decision-making capacity.

As expressed in the [APS submission to the Royal Commission into Aged Care](#) (p.12) decision-making capacity is a very complex area that spans legal and medical sectors (“medicolegal”). Due to these complexities, capacity assessments are by necessity conducted by a select few professions, classically medical doctors, specialists, lawyers and psychologists. Psychologists are in a unique position to conduct capacity assessments for several reasons. Psychologist’s core skills include combining evidence-based assessments of cognition and behaviour, with the ability to differentiate between the impact of certain conditions (e.g. mental illness, dementia, delirium) on decision-making. Specifically, clinical neuropsychologists and forensic are acknowledged for their skills in conducting capacity assessments for complex matters.

(b) is not able to determine if the person has a disease, illness or medical condition that meets the eligibility criteria—they must refer the person to: (i) a specialist medical practitioner with appropriate skills and training in that disease, illness or medical condition (as in Victoria); or (ii) a health practitioner with appropriate skills and training (as in Western Australia);

The WA approach gives coordinating practitioners or consulting practitioners a broader range of appropriate specialists who might not be medical practitioners. This is important in the light of the Victorian implementation, whereby several cases reported in the media indicated that patients died while waiting to have their eligibility assessed due to not being able to access an appropriate medical practitioner.

(c) is not able to determine if the person is acting voluntarily and without coercion—they must refer the person to another person who has appropriate skills and training to make a determination in relation to the matter (as in Western Australia)?

The APS supports the WA approach. However, referral must be done in a timely manner. Referral to a psychologist may be appropriate to determine decision-making capacity, and this process requires that a person can demonstrate they have made their decision freely without undue influence.

Q-33 Should the draft legislation provide that an interpreter who assists a person in requesting or accessing voluntary assisted dying must be accredited and impartial, in similar terms to the legislation in Victoria and Western Australia?

Yes. People from culturally and linguistically diverse backgrounds should not be disadvantaged either by a lack of impartial and accredited interpreters, or because they haven't been appropriately informed about voluntary assisted dying.

Q-41 Should a registered medical practitioner who has a conscientious objection to voluntary assisted dying be required to refer a person elsewhere or to transfer their care?

As stated in the [APS submission to the Queensland Inquiry](#) (p.11), there is a risk that an individual who would like assistance to die may not be able to access a practitioner who supports their decision. Health practitioners who object to participating in facilitating the process should be required to refer patients to other health practitioners who do not hold such a position.

Dying people may be at the limit of their mental, physical and economic resources and find it very difficult to locate another health practitioner who does support assisted dying. This is particularly true for individuals living in rural and remote areas, as well as those in residential aged care or palliative care facilities (where patients are entirely dependent on visiting medical practitioners who attend to them). Finding an alternative medical practitioner oneself in these circumstances may be excessively onerous or impossible.

In the event a psychologist has a conscientious objection to voluntary assisted dying, the APS encourages its members to refer clients on as appropriate (see [What psychologists should know about voluntary assisted dying](#), InPsych 2019). If psychologists choose to conscientiously object, they might still find that in some circumstances they are ethically obliged to provide support. For example, when a psychologist is seeing a client with issues completely unrelated to voluntary assisted dying, and then the client is diagnosed with a terminal illness. According to the [APS Code of Ethics](#), should this client express an interest in voluntary assisted dying then the psychologist must do so in a way that ensures appropriate services to the client continues (whether by continuing to provide support or referring on). Issues of non-abandonment were considered by Palliative Care Australia and are addressed in their 2019 [guiding principles concerning voluntary assisted dying](#).