Joint Committee on Assisted Dying; Tuesday 7th November 2023

Opening statement: Anne M. Doherty MD MMedSc FRCPsych

Thank you, Cathaoirleach and members of the Joint Committee on Assisted Dying for inviting me to contribute to this morning's considerations on Assisted Dying.

In this opening statement I will focus on my clinical experience of working with people who have expressed a wish to die, including those with an incurable or life-limiting condition. I am confident that everyone in this room shares a vision for the highest standard of end-of-life care, which prioritizes access to necessary treatment, and supports the avoidance of suffering, and the highest levels of dignity and autonomy.

I am a consultant liaison psychiatrist; Liaison Psychiatry is the medical specialty for the integrated care of people with mental and physical health problems together. I currently have two areas of specialist work, I am the local Clinical Lead for Self-Harm and Suicide-related ideation, and as part of the Psycho-Oncology Service, providing mental health care to people with cancer.

Ireland has had notable success in reducing suicide rates in the past decade. While it is difficult to attribute this to any one factor, it is likely that the Clinical Programme for Self-Harm and Suicide related ideation has impacted on this. [1] The programme is based on the framework that no problem or set of circumstances is unsurmountable, and that, with good mental health care, suicide can be avoided.

The Psycho-oncology Programme of the National Cancer Control Programme was established to meet the mental health needs of people with cancer. [2] As part of this programme, I work as part of a team treating people with mental health challenges, including severe depression and people who want to die. Not everyone who has thoughts of not wanting to be alive is necessarily suicidal, emotions such as helplessness, physical symptoms, mental health symptoms and deficits in social care provision can all contribute to a varying degree, and every individual's experience is different. Thoughts of not wanting to live can range from a passive death wish (where the person feels it might be good if they were to die in their sleep), to thoughts of suicide, to plans for suicide, to suicidal acts. The palliative care literature also describes the wish to hasten death, which has similarities to passive death wish. [3,4]

I have treated countless patients with cancer who have had suicidal thoughts. This is not unusual according to the scientific literature around the mental health care of this population.[5] In my experience, with a compassionate approach and the highest possible standard of mental health care we can treat these problems and restore quality of life. The scientific data notes that depression is very treatable in people receiving end of life care, with high recovery rates reported in the literature.[6,7.]

Speakers to date have been clear that those with mental illness will be excluded from such legislation. However, the premise of these types of laws in other countries such as Queensland,

Australia is founded on the basis that the person is experiencing intolerable suffering which cannot be relieved.[8] Can mental distress be as severe as physical symptoms in terms of quality of life? Absolutely yes, and this is why in Canada a court challenge has resulted in a change in the law to allow people to access assisted suicide on grounds of mental illness alone. [9,10]

This session is entitled **Protecting autonomy and decision-making capacity**. Is it possible to have robust safeguards which would prevent someone with a treatable depression from accessing assisted dying? The Danish Council of Ethics had doubts about the feasibility of this, stating in their recent report that it was *"in principle impossible to establish proper regulation of euthanasia"*. [11]

People can have a significant depression, with symptoms which include low mood, hopelessness, negativity towards the future and a wish to die, without necessarily lacking capacity. However, in such a case the person's low mood will certainly affect how they think and how they experience emotion. It's hard to know how we would robustly ensure that a person in this situation would receive mental health treatment if they had an entitlement under the law to assisted dying. As well as mental health conditions and cognitive conditions, there are a range of psychosocial factors which might impact on decision-making such as coercion and elder abuse.

In last year's systematic review, we examined the relationship between suicide and assisted dying,[12] intrigued by the argument that assisted dying would in fact reduce suicide rates. [13,14] A systematic review is a rigorous research methodology, where, following a search for all relevant research in an area, the studies are evaluated for their quality. We found that in countries where any form of assisted dying was introduced, that there was no overall reduction in self-initiated deaths, and that overall, suicide rates did not significantly change. We identified that in Oregon and Switzerland the research reported a significant increase in older women seeking assisted dying and dying by suicide, and this is concerning because older women have high rates of depression. [15,16] This trend raised the question of whether these deaths were being driven by potentially treatable depressive illnesses being left untreated, and whether there is a gendered impact influencing this.

While mental health awareness and access to supports has improved in recent decades, there remains stigma towards mental health challenges in our society, and mental healthcare receives <6% of the health budget (12-13% in comparable countries). We need to address this and ensure that we are providing the highest standard possible of health care both mental and physical and that people have full access to adequate palliative care and mental healthcare. It would be a travesty if assisted dying became a substitute for assistance in living.

Thank you.

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