

Voluntary assisted dying for people with mental disorder

Saxby Pridmore ^{1#}, Ahmed Naguy ², Jamshid Ahmadi ³, William Pridmore ⁴

¹College of Medicine and Health, University of Tasmania, Australia; ²Kuwait Centre for Mental Health, Shuwaikh, Kuwait; ³Substance Abuse Research Center, Shiraz University of Medical Sciences, Shiraz, Iran; ⁴Launceston General Hospital, Launceston, Tasmania, Australia

Correspondence: Prof. Saxby Pridmore Email: s.pridmore@utas.edu.au

Received: 4/10/2020; **Accepted:** 16/10/2020

Key words: mental disorder, vulnerability, decisional capacity, suffering.

[**citation:** Pridmore, Saxby; Naguy, Ahmed; Ahmadi, Jamshid; Pridmore, William (2021).

Voluntary assisted dying for people with mental disorder. DHH,

8(1):https://journalofhealth.co.nz/?page_id=2457].

Abstract

Background: Four European countries make voluntary assisted dying (VAD) available to people experiencing distress/suffering from either physical diseases or mental disorders. Outside Europe, VAD is only available to those with physical diseases.

Objective: To argue VAD should also be available to people suffering primary mental disorder and to suggest some eligibility criteria.

Conclusion: Australian and New Zealand VAD eligibility criteria should be modified to allow mental disorder. The distinction between physical and mental disorder is spurious. The current requirement that the disorder must be terminal should be extinguished. That some people with mental disorders lack capacity does not justify a blanket embargo excluding all such people from receiving VAD. People with mental disorder complete suicide at a greater rate than those who do not have mental disorder, proving that mental disorder may make life, for some people, not worth living. We propose some eligibility criteria. VAD applicants with mental disorders must have reached majority and possess decisional capacity. The person must find the suffering from the mental disorder makes life not worth living. The request and completion of VAD must not be impulsive but well considered. The mental disorder must have been present for a protracted period (longer than expected) and treatments have failed to satisfactorily reduce the suffering.

1. Introduction

The countries of the world form two groups, 1) those which allow voluntary assisted dying (VAD), and 2) those which do not. Those countries which do allow VAD form two groups, a) those which provide VAD using broad eligibility criteria and, b) those which use narrow eligibility criteria.

Group 1(a) are all European countries and include Switzerland, the Netherlands, Belgium, and Luxemburg. The eligibility criteria vary somewhat between jurisdictions - they do not mandate terminal illness must be present. They list general suffering and mental disorder as justifying criteria.

Group 1(b) are all non-European regions and include the US state of Oregon, Colombia, Canada, and Victoria (Australia). Western Australia and New Zealand have passed legislation, and implementation is proceeding. The eligibility criteria for these countries include that terminal illness must be present. Additionally, the illness must be incurable, causing the person to consider life not worth living, and expected to cause death within 6 months (12 months in the case of neurodegenerative disease).

Two features of the legislation of Australia, New Zealand and the other non-European countries prevent people with primary mental disorder receiving VAD. The first is the criterion that the disease is expected to cause death in the near future. This implicitly excludes primary mental disorders. The second is an explicit exclusion, that mental disorder is not sufficient justification for VAD. For example, the Victorian Act, Sect 9(1)(d) states “a person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness”. The New Zealand Act, Sect 5(2)(a) states a person is not eligible “by reason only that the person – is suffering from any form of mental disorder or mental illness”.

There are likely numerous thoughts/beliefs/emotions underpinning the exclusion of those with mental disorder from VAD. Jones and Simpson (2018) suggest that assisting death is controversial, but that when death is imminent, the relief of suffering supersedes the ethical responsibility to protect life. Opponents of VAD claim that people with mental disorders lack the capacity to make decisions about their management, are *vulnerable* and must be protected. It is argued, the most certain way to protect this group of people is to exclude them from participation (Dembo et al., 2018; Mendez and Kissane, 2020). There are also suggestions that mental disorders are more tolerable than physical disorders and that it is not possible to know that a psychiatric disorder is “incurable”, as remission may still be possible after 20 years of no response to treatment with a dozen medications and ECT (Kim and Lemmens, 2016a).

We argue that VAD should also be available to people with primary mental disorder.

2. Examination of theory and legislation

We examined a range of theoretical material and VAD legislation and make the following observations.

2.1 Physical versus mental disorders

The distinction between physical and mental disorders is not justified. This false distinction has enabled the discriminating embargo preventing people with mental disorders receiving VAD. People develop diseases/disorders, not minds, or bodies. For two and a half millennia ‘mind-body dualism’ has been a way of thinking about human beings. A comprehensive rebuttal of dualism is beyond the scope of this paper. However, the mind is a function of the brain (a bodily structure). Physical pathology of the brain may present with hallucinations or delusions – that is, as symptoms of the ‘mind’. Most mental disorders have a strong genetic basis – genes associated with mental disorder influence the structure of the brain (a body structure). It is also important to recognize the reverse also holds, our minds change the structure of our brains - when we learn something (the two times table, for example) there is a change in our brain structure and its subsequent function.

The division of diseases/disorders is convenient for some practical purposes – it is better for people with heart disease to attend the heart than the podiatry clinic. Hip disease and dementia are both more common in the elderly and manifest body structure pathology – one features ache and a limp and the other features forgetfulness and possible delirium – but both are experienced by the person. The mind-body distinction provides different ways of viewing the complete person.

Physical brain abnormalities are well described for all the major mental disorders, including schizophrenia (Roes et al., 2020), depression (Batail et al., 2020), panic disorder (Ni, et al., 2020), and obsessive-compulsive disorder (Peng et al., 2012).

Disease is defined as “the sum of the abnormal phenomena displayed by a group of living organisms in association with a specified common characteristic or set of characteristics by which they differ from the norm for their species in such a way as to place them at a biological disadvantage” (Scadding, 1967, p 877). This definition applies equally to physical disease and mental disorder.

2.2 Vulnerability

Opponents of VAD argue that ‘vulnerable’ people can be coerced into ending their lives, and that people with physical diseases, mental disorders or personal problems are impaired by these issues such that they are vulnerable. Therefore, opponents argue, VAD should not be available to people with such issues. This argument is particularly prosecuted in opposition to VAD for people with mental disorders – because, it is claimed, this category of people is the most likely to be vulnerable.

Bioethicists describe vulnerability as a vague term with no agreed definition and caution that it stereotypes groups of diverse patients (Levine et al., 2004). The so-called vulnerability of people with mental disorders “appears to derive from concerns about competence” (Rooney et al 2017., p.332) - that is, the possession of decision-making capacity. Decision-making capacity can be reliably assessed (see below) and may improve with the passage of time and treatment.

There is no evidence from any jurisdiction of vulnerable people receiving more VAD than the general population (Emanuel et al., 2016; Ganzini., 2016). While there has been an increase in the number of people with mental disorder receiving VAD in the Netherlands in recent years, there has been no shift in patient characteristics (van Veen et al., 2019). The exclusion of people with mental disorders from VAD services based on a presumed need for special protection is not supported by evidence and bears features of a conspiracy belief.

2.3 Suicide

Some suicide is attributable to mental disorder. There is a strong argument that the proportion of those who suicide as a consequence of mental disorder has been greatly exaggerated (Shahtahmasebi 2013, 2014).

It has been argued that people with mental disorder do not need VAD because they can suicide if they so wish (Dembo et al, 2018). This is an offensive argument.

Suicide is a lonely, frightening, and commonly unsuccessful. We have known patients who have survived cutting, shooting, jumping, and self-immolation – usually adding to their disability burden. A case to be made for providing VAD to people with mental disorder to protect against the lonely frightening experience of completed suicide and any additional disability burden from failed suicide.

2.4 Capacity

The Victorian Act, Sect 9 (1)(c) states the applicant must have “decision making capacity”, and the New Zealand Act, Sect 5(1)(f) states the applicant must be “competent to make informed decisions”. Decision making capacity refers to the ability to receive, retain and weigh information, form conclusions/decisions and convey them to others (Shaw et al., 2018) – it applies equally to having your hair dyed or your leg amputated. The eligibility requirement of decisional capacity for those requesting VAD is uncontested.

Psychiatric patients may lack decisional capacity (at least for periods). However, not all psychiatric patients have enduring lack of decisional capacity. Cross-sectional studies using standardized instruments show that 20-30% of involuntarily hospitalized psychiatric patients lack decisional capacity – the corollary is that the majority (70-80%) retain capacity (Candia and Barba, 2011). Importantly, such studies are conducted on recently admitted acute patients – care and treatment generally improves symptoms (at least to some extent) and this may be reflected in improved capacity. Further, VAD is considered when the patient is settled, not during an acute episodic disturbance.

If there is doubt regarding capacity, a focused psychiatric examination is mandatory. Psychiatrists are trained in the assessment of decisional capacity - it is commonly performed by Liaison Psychiatrists when surgical or other physical services are being considered. The assessment process is similar to that used in the determination of fitness to plead, the insanity defence, and testamentary capacity.

To exclude all people with mental disorder from VAD on the basis that some have impaired decisional capacity at some time is unacceptable paternalism (Dembo et al, 2018; Shaw et al, 2018; Jones et al, 2018; Rooney et al, 2017).

2.5 Incurable

In most jurisdictions, VAD eligibility criteria include that the “disease, illness or medical condition” must be “incurable” (see Victorian Act, Sect 9(d)(i) and New Zealand Act, Sect 5(1)(d)). Incurability means the suffering will be protracted – it suggests severity and that death will result.

Opponents of VAD for people with mental disorder claim it is impossible to determine that a mental disorder is incurable (Kim and Lemmens, 2016a). However, most psychiatrists have known patients who have not responded to any treatment over decades. The incurability requirement goes a good way to ensuring the patient’s circumstances are grievous.

Contextually, it is important that existing psychiatric treatments have limitations and advances in the field are slow – for example, some mood stabilizers, antidepressants, and antipsychotics which were discovered in the first half of the 20th century are still among the first line treatments.

Rush et al (2006) studied major depression in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) project. Four therapeutic steps including psychotherapy and a range of antidepressant medications and augmenting agents were delivered. Thirty % of patients did not respond (even moderately improve) to any treatment, and of those who did, 70% relapsed in the first year. A course of ECT (the strongest standard antidepressant treatment) produces remission in only about 50% of episodes and there is 50% relapse in one year (Cabelguyen et al., 2020). Deep brain stimulation (DBS) for resistant depression provides inconsistent outcomes and requires further development (Roet et al., 2020).

A recent study of outcomes in schizophrenia found that 66.9% of people treated with antipsychotic medication failed to achieve remission (Samara et al., 2019). Ablative surgery for OCD provides satisfactory/valued outcomes for some patients but unfavourable outcomes are common (Lai et al., 2020).

A study of people with mental disorders who had received VAD in the Netherlands found that 68% had a history of more than 11 years and 27% a history of more than 30 years (Kim et al., 2016b). Thirty-nine % of this cohort had received ECT, and others had failed to respond to DBS.

It is impossible to prove that particular cases of mental disorder are curable or incurable - should the patient live for a thousand years a cure will almost certainly become available. Mental disorders cause great suffering and frequently persist for longer than a decade.

2.6 Terminal

As mentioned, the VAD eligibility criteria in most regions include that the person must be suffering a terminal illness (see Victorian Act, Sect 9(d)(ii) and New Zealand Act, Sect 5(1)(c)) and that death is anticipated in the near future. This has implications for those with mental disorders. Mental disorders are not regarded as terminal illnesses - thus, this criterion excludes those with mental disorders. Another implication of this criterion is that if a mistake were made, less than six months of life would be lost.

The requirement that the disease/disorder be terminal is a means of ensuring that the situation is serious/grievous. Two other criteria (the presence of great suffering and incurability) substantiate an adverse situation. In our opinion, the requirement for imminent death should be extinguished - if the person is experiencing great suffering and finds life not worth living, and the condition is unresponsive to treatment, we should respect the request for VAD.

2.7 Suffering

Suffering is an eligibility criteria of all VAD legislation. In the Victorian Act, for example, Sect. 9(2)(d)(iv) states “causing suffering to the person that cannot be relieved in a manner that the person considers tolerable”. The New Zealand Act, Sect. 5(1)(e) has the same in meaning.

Dembo et al. (2018, p 453) observe that some who support VAD for physical disease but not for mental disorder believe “that suffering in the former group is more unbearable than in the latter”. As suffering is a subjective matter, it is impossible and discriminatory to make this claim.

The brain events underpinning major depressive disorder trigger sadness and unfounded guilt, just as a cancer pressing on the sciatic nerve triggers pain down the leg. Other painful depressive disorder symptoms include the inability to experience pleasure, the wish to die, anxiety and panic attacks, insomnia, and loss of appetite, weight, decisiveness, and energy.

Those suffering treatment resistant obsessive-compulsive disorder are distressed by their thoughts and spend such time cleaning, checking, and rearranging that they are unable to function in the normal manner - they may be unable to participate effectively in employment and family life.

Those suffering schizophrenia may have delusions of persecution and danger, hear critical/threatening voices and experience frightening visions. There is an undesired loss of drive, energy and ability to enjoy pleasure/rewards. Such people occupy low status positions in society and may be homeless. Many remain acutely aware of their limitations and losses.

Severe mental disorder is associated with severe physical disorder – leading to a 10-25 year reduction in life expectancy. The mortality rate of people with bipolar disorder and schizophrenia is 2-2.5 times higher than the general population. Compared to the general population, people with mental disorders have higher rates cardiovascular, respiratory, and infectious disease (including HIV and tuberculosis), diabetes and hypertension (WHO, undated).

This poor general health outcome is influenced by socioeconomic, lifestyle, biological and treatment issues. Smoking is common among people with mental disorder, which is attributable to underactive brain pleasure centres. Lack of exercise and obesity (consequences of lack of drive, energy and ability to experience pleasure, and the sedative effects of medication) lead to physical problems. There is a strong association between schizophrenia and Type II diabetes (20-30% comorbidity); this is doubtlessly underpinned by lifestyle factors, but shared genes are a possible contributor (Perry et al., 2020). Most psychiatric medications interfere with metabolism and cause weight gain.

More people with mental disorder than without mental disorder complete suicide, proving that mental disorder is a cause of great suffering.

3. Conclusion

VAD (for people with physical disease) has been recently legalized in New Zealand and parts of Australia. There are also moves in this direction in other countries - societal attitudes appear to be changing.

However, people in New Zealand and Australia with mental disorders are currently excluded from VAD services. Those people with the ability to influence legislation often have little knowledge or experience of the mental disorders. Those who suffer severe mental disorder are not well able to advocate for themselves due to their disorder. They suffer greatly, lack experience in pushing political agendas, and some have subtle cognitive impairment.

The argument that people with mental illness will commit or attempt suicide anyway, so let's offer them assistance with dying, does not fit with current suicide prevention policies.

Globally, suicide prevention policies consider the wish to die as proof of mental illness. When suicide is mentioned there is frequently a search for a diagnosis and the application of a treatment. It has been argued that the predestined linking of suicide and mental disorder by 'experts' leads some people from revealing their predicament, knowing they will be automatically labelled/dismissed as 'mentally ill' (Shahtahmasebi 2013, 2014). Thus, a large proportion of all suicide cases do not come into contact with psychiatric services and are successful in their first attempt, whilst some others are unsuccessful sometimes with disabling outcomes. However, including the group with mental illness in a modified VAD service that offers assistance with appropriate education and guidance may positively affect suicide prevention.

3.1 Proposed eligibility criteria

We have drawn on theoretical material and extant VAD legislation and have offered some argument in support of VAD for those suffering mental disorders. We suggest these eligibility criteria. The applicant 1) is at least 18 years of age, 2) has decisional capacity, 3) has reached a considered, stable decision, and 4) is experiencing suffering such that he/she finds life not worth living. 5) The disorder has been present for an adequate period and 6) all the treatment which the applicant considers acceptable have been given an adequate trial, without substantial improvement.

1. All current VAD laws require the person to have reached maturity (although special arrangements are sometimes made for younger people). This criterion should persist.
2. All current VAD laws require the person to possess decision making capacity and this criterion should persist. Should there be uncertainty in a particular case, expert assessment is essential. Psychiatrists are skilled in assessing capacity and should impairment be detected, may also have some advice on steps which may improve capacity.
3. The applicant must have given the making of an application for VAD considerable thought - quantifying a 'cooling off' period as applies with some major financial deals may be appropriate. Current VAD legislation stipulates implementation protocols which impose a timetable structure and the requirement for reassertion (verbal and written) of the request.
4. All current VAD laws require the person to be suffering and this criterion should persist. The suffering of people with mental disorder is multifaceted and impacts all aspects of life. It arises from the disorder itself and consequent events including physical problems. The suicide rate of people with mental disorder is greater than that of people without mental disorder, which proves the suffering of this group is great.
5. The disorder needs to have been present for a protracted period. At this point we do not attempt to define 'protracted'. Certainly, it means longer than expected, or generally experienced. This clause is an alternative to the criterion of 'incurable' which occurs in much VAD legislation. It is not possible to state that a disease/disorder is incurable insofar as remission may unpredictably occur, however, it is possible to state that a disorder has been present for a protracted (longer than expected) period and there

are no signs of resolution. This circumstance combines with suffering in justifying VAD.

6. All treatments which the patient finds acceptable must have been given an adequate trial. In particular, psychotherapy and medication need to have been given at recommended doses for at least the recommended period. Transcranial magnetic stimulation may not be available, and the patient may reasonably reject electroconvulsive therapy, deep brain stimulation and ablative surgery.

Funding/Conflict of interests: This research did not receive any specific grant from funding agencies in the public, commercial or not-for profit sectors. We have no conflict of interests.

Acknowledgement: We are most grateful to David Clarke PhD for invaluable assistance with the topic of mind-body dualism.

References

- Batail, J., Coloigner, J., Soulas, M., Robert, G., Drapier, D., 2020. Structural abnormalities associated with poor outcome of major depressive episode: the role of the thalamus. *Psychiatry Res. Neuroimaging* 305, 111158.
- Cabelguen, C., Caillet, P., Poulet, E., Szekely, D., Desmidt, T., Pichot, A., Vanelle, J-M., Sauvaget, A., Bulteau, S., 2020. Recurrence after stopping maintenance electroconvulsive therapy: a retrospective case series. *J. ECT.* 36, 265-271.
- Candia, P., Barba, A., 2011. Mental capacity and consent to treatment in psychiatric patients: the state of research. *Curr Opin Psychiatr* 24, 442-446.
- Dembo, J., Schuklenk, U., Reggier, J., 2018. "For their own good": a response to popular arguments against permitting medical assistance in dying (MAID) where mental illness is the sole underlying condition. *Can. J. Psychiatry* 63, 451-456.
- Emanuel, E., Onwuteaka-Philipsen, B., Uren, J., Cohen, J., 2016. Attitudes and practices of euthanasia and physician assisted suicide in the United States, Canada, and Europe. *JAMA* 316, 79-90.
- Ganzini, L., 2016. Legalized physician assisted deaths in Oregon. *QUT Law Review* 16, 76-83.
- Jones, R., Simpson, A., 2018. Medical assistance in dying: challenges for psychiatry. *Front. Psychiatry* 9: Article 678.
- Kim, S., Lemmens, T., 2016a. Should assisted dying for psychiatric disorders be legalized in Canada? *CMAJ* 188, E337-E339.
- Kim, S., De Vries, R., Peteet, J., 2016b. Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011-2024. *JAMA Psychiatry* 73, 362-368.
- Lai, Y., Wang, T., Zhang, C., Lin, G., Voon, V., Chang, J., Sun, B. 2020. Effectiveness and safety of neuroablation for severe and treatment-resistant obsessive-compulsive disorder: a systematic review and meta-analysis. *J. Psychiatry Neurosci.* 45, 356-369.
- Levine, C., Faden, R., Grady, C., Hammerschmidt, D., Eckenwiler, L., Sugarman, J., 2004. The limitations of "vulnerability" as a protection for human research participants. *Am J Bioeth.* 4, 44-49.
- Mendez, G., Kissane, D., 2020. Agency, autonomy and euthanasia. *J. Law Med. Ethics* 48, 555-564.

- Ni, M-F., Wang, X-M., Wang, H-Y., Chang, Y., Huang, X-F., Zhang B-W., 2020. Regional cortical thinning and cerebral hypoperfusion in patients with panic disorder. *J. Affect. Disord.* 277, 138-145.
- Peng, Z., Lui, S., Cheung, E., Jin, Z., Miao G., Jing, J., Chan R., 2012. Brain structural abnormalities in obsessive-compulsive disorder: converging evidence from white matter and grey matter. *Asian J. Psychiat.* 5, 290-296.
- [Perry](#), B., [Jones](#), H., [Richardson](#), T., Zammit, S., Wareham, N., Lewis, G., Jones, P., Khandaker, G. 2020 Common mechanisms for type 2 diabetes and psychosis: findings from a prospective birth cohort. *Schizophr. Res.* 223, 227-235.
- Roes, M., Yin, J., Taylor, L., Metzac, P., Lavigne, K., Chinchani, A., Tipper, C., Woodward, T., 2020. Hallucination-specific structure-function associations in schizophrenia. *Psychiatry Res. Neuroimaging* 305, 111171.
- Roet, M., Boonstra, J., Sahin, E., Mulders, A., Leentjens, A., Jahanshahi, A., 2020. Deep brain stimulation for treatment resistant depression: toward a more personalized treatment approach. *J Clin Med* 9, 2729.
- Rooney, W., Schuklenk, U., van de Vathorst. S., 2018. Are concerns about irremediableness, vulnerability, or competence sufficient to justify excluding all psychiatric patients from medical aid in dying? *Health Care Anal.* 26, 326-343.
- Rush, A., Trivedi, M., Wisniewski, S., Nierenberg, A., Stewart, J., Warden, S., Niederehe, G., Thase, M., 2006. Acute and longer-term outcome in depressed outpatients requiring one or several treatment steps: a STAR*D report. *Am. J. Psychiatry* 163, 1905-1917.
- Samara, M., Nikolakopoulou, A., Salanti, G., Leucht, S., 2019. How many patients with schizophrenia do not respond to antipsychotic drugs in the short term? An analysis based on individual patient data from randomized controlled trials. *Schizophr Bull.* 45, 639-646.
- Scadding, J., 1967. Diagnosis: the clinician and the computer. *Lancet.* 2(7521), 877-882.
- Shaw, D., Trachsel, M., Elger, B., 2018. Assessment of decision-making capacity in patients requesting assisted suicide. *Br. J. Psychiatry* 213: 393-395.
- Shahtahmasebi, S. (2013). " Examining the claim that 80-90% of suicide cases had depression." *Frontiers in Child Health and Human Development*, 1(62); DOI 10.3389/fped.2013.00008.
- Shahtahmasebi S (2014). Suicide research: problems with interpreting results. *British Journal of Medicine and Medical Research*: 5(9), 1147-1157. from <http://www.sciencedomain.org/issue.php?iid=716&id=12>.
- van Veen, S., Weerheim, F., Mostert, M., van Delden, J., 2019. Euthanasie van Nederlandse psychiatrische patienten in 2015-2017. [Euthanasia of Dutch psychiatric patients in 2015-2017.] *Tijdschr. Psychiatr.* 61, 241-247. (Dutch)
- World Health Organization, (Undated). Premature death among people with severe mental disorders. https://www.who.int/mental_health/management/info_sheet.pdf?ua=1 (Accessed 25 September 2020)