National Suicide Research Foundation
NSRF

Assisted dying legislation: Considerations for suicide prevention, research and policy development

Submission to the Joint Committee on Assisted Dying

on behalf of the National Suicide Research Foundation (NSRF)

November 8th 2023

Key findings

- Even though an increasing number of countries have introduced legislation to facilitate assisted dying for people with physical health conditions and, in more recent years for people with mental health conditions, there is limited information about the implementation of this legislation and procedures involved.
- Based on the available research, there is no consistent evidence that rates of suicide change as a result of assisted dying legislation, with no study reporting a decrease in suicide rates as a result of such provisions. However, research in this area is significantly hampered by the lack of reliable data on deaths both by assisted dying and by suicide.
- The profile of individuals who die via assisted dying seems to be distinct from the profile of individuals who die by suicide. Those who die by assisted dying are generally older in age and are more likely to be female. However, some potential risk factors are shared by both groups, including living alone, having no children, and not identifying as being religious.
- The prevalence of psychiatric co-morbidities in individuals who die by assisted dying is difficult to establish, with reported proportions ranging from 3-39%.
- The risk of suicide following a terminal or chronic illness is highest in the first six months after diagnosis.
- Research is lacking on the safeguarding process within frameworks for implementing assisted dying legislation and may negatively impact on patients experiencing psychiatric conditions in particular.

There are a number of important recommendations arising from research studies, addressing knowledge gaps and priorities, and informing any consultation for legislation around assisted dying, including:

Research recommendations

- Estimating the risk of suicide in Ireland following diagnosis of a chronic and/ or terminal physical illness or a psychiatric disorder, including an examination of sociodemographic and clinical factors.
- Evaluating the effectiveness and implementation of timely mental health interventions for individuals recently diagnosed with a chronic and/ or terminal physical illness or a psychiatric disorder.
- Exploring the motives among individuals requesting assisted dying, with a focus on psychiatric and physical comorbidities and gender- and age-related differences.
- Examining attitudes of health and mental health professionals in relation to assisted dying, taking into account the role of psychiatric conditions and psychiatric and physical health co-morbidities.

Policy recommendations

- Prioritise development and implementation of interventions for people recently diagnosed with a chronic or terminal illness and older adults, in particular those experiencing physical and mental health comorbidities, identified as priority groups in Ireland's National Suicide Prevention Strategy, Connecting for Life, 2015-2024.
- Reduce health inequalities and optimise standardised access to health and mental health services across all regions in Ireland.
- Greater involvement of mental health professionals in the debate about assisted dying and addressing mental health professionals' role in the assessment of patient competency and decision-making capacity. Given the lack of reliable data on deaths both by assisted dying and by suicide internationally, if a change in Irish legislation was to occur around assisted dying, it should be accompanied by a comprehensive data recording system, in order to monitor trends in both assisted dying and suicide at a national level.
- There is a lack of evidence regarding the effectiveness of safeguards, especially in vulnerable groups, due to the lack of recording of data and what safeguards were undertaken. If a change in Irish legislation occurs, it is not clear what safeguards will be deemed sufficient based on the international experience and in which statutory body will be responsible for determining whether safeguards have been successful.

Background

The number of countries and jurisdictions establishing laws in relation to euthanasia and assisted dying has increased, in particular, during the 21st century. Since the late 1990s, euthanasia and assisted dying have been legal in The Netherlands, while assisted dying has been legal in Switzerland and some US states. Other jurisdictions such as Belgium, Canada and some Australian states have introduced similar legislation more recently. While initially legislation was limited to terminal physical health conditions, most commonly for individuals suffering from cancer, in recent times some countries have permitted euthanasia or assisted dying for psychiatric conditions, including young people. For example, from 2024, Canada will permit assisted dying in the absence of a terminal physical illness.

There have been diverging hypotheses on the impact of assisted dying legislation on population rates of suicide. On the one hand, it has been theorised that the legalisation of assisted dying may reduce the rate of suicide and potentially the rate of suicide plus assisted dying (Posner, 1997). The associated reasoning being that in the absence of assisted dying legislation, individuals may die by suicide at an earlier point than might otherwise be the case. It is also argued that suicide rates may decrease, as people will choose to die via supported means rather than via a violent suicide death. On the other hand, there are concerns that a change in legislation could have the opposite effect and lead to an increase in population rates of suicide, underpinned by an increase in the discourse and social acceptability of suicide within the general population (Doherty et al., 2022).

Irish policy context

In June 2023 a Joint Committee on Assisted Dying was formed to consider and make recommendations for legislative and policy change relating to a statutory right to assist a person to end his or her life (assisted dying) and a statutory right to receive such assistance.

This discussion paper has the following aims, specifically to:

1. Summarise research examining the impact of the introduction of assisted dying on rates of (non-assisted suicide) in the general population.
2. Examine the difference in profile of people who die by suicide and assisted dying.
3. Describe the risk of suicide associated with terminal or chronic physical illnesses.
4. Outline research examining the safeguarding process for patients seeking euthanasia or assisted dying.

The impact of the introduction of assisted dying on rates of (non-assisted) suicide in the general population

A single systematic review has examined the relationship between euthanasia and/or assisted dying and rates of suicide (Doherty et al., 2022). This review identified six studies, published between 1996 and 2021, representing studies from Switzerland, The Netherlands, Belgium and the US. The review highlighted variation in the methodological quality of included studies. **The review concluded that there was no evidence to support the hypothesis that suicide rates decreased in countries introducing assisted dying practices, but also no consistent evidence for an increase in suicide rates.**

A more recent US study (Girma & Paton, 2022) reported a small increase in suicide in states with assisted dying legislation. One report from the Federal Statistical Office in Switzerland (Federal Statistical Office, 2016) reported that the rate of assisted dying in Switzerland has increased each year between 2000-2014. The report states that the increase in assisted dying compensates for the decrease in suicide over the time period. The report goes on to underline, however, that these changes represent, for the most part, two different populations.

Comparing the profile of people who die by assisted dying and those who die by suicide

For the most part, most people who die via assisted dying are over the age of 55 years (Federal Statistical Office, 2016), with young people under 35 years accounting for between 0.5-1.3% of these (Federal Statistical Office, 2016; Steck et al., 2016). However, legislation facilitating assisted dying among people under the age of 35 has been implemented in a small number of countries in recent years. Research has shown that, compared to suicide, women aged 65 years and older are at increased risk of assisted dying, accounting for approximately half of all assisted dying deaths (Canetto & McIntosh, 2022; Steck et al., 2016), compared with one-fifth of suicide deaths (CSO, 2019). The gender ratio in assisted dying by older people appears to more broadly reflect the gender distribution in the general population (CSO, 2022). Even though assisted dying may be empowering for women diagnosed with a terminal or life-limiting illness, it has been argued that women may be more likely to feel that they are a burden, and therefore more likely to elect for assisted dying than their male counterparts. In addition to the aforementioned gender differences, a Swiss study (Steck et al., 2016) found that higher education was positively associated with assisted dying and negatively

associated with suicide. With both forms of death, some potentially vulnerable risk factors were identified, including living alone, having no children, and not identifying as religious.

It is difficult to ascertain the true prevalence of psychiatric illness among people who die via euthanasia/ assisted dying. Data from Switzerland estimate that between 3-5% of people had a diagnosis of a mental illness (Steck et al., 2016). Yet, depression consistently goes undetected and undiagnosed by non-psychiatrically trained primary care physicians. Considering the well-established link between depression and suicide, it is likely that the prevalence of depression, and other mental health conditions, is under reported among people requesting assisted dying (Mitchell et al., 2009). A Canadian chart review study of 155 patients requesting medical assistance in dying (MAID) (Isenberg-Grzeda et al., 2021), found that 39% had a documented psychiatric comorbidity, most commonly depression or anxiety. There was no variation in demographics and physical health diagnoses between patients with and without a psychiatric co-morbidity. A systematic review of psychiatric patients seeking euthanasia or assisted dying (Calati et al., 2021) found that rates of psychiatric patients requesting access to assisted dying has increased. Those patients are primarily women (70-77%), diagnosed with at least two psychiatric disorders (56-97%), between 37-62% of which had at least one comorbid physical health condition.

The relationship between suicide and chronic/terminal illness

A recent study from England found that diagnosis of severe physical health conditions was associated with an increased risk of dying by suicide, particularly for low-survival cancer patients and individuals suffering from degenerative neurological conditions. The increase in risk was more pronounced in the first six months after diagnosis or first treatment and was similar for both men and women (Nafilyan et al., 2023). There is very little research from an Irish context on the relationship between suicide risk and terminal or chronic illness. An Irish psychological autopsy study found that 57% of people who died by suicide had been diagnosed with a physical illness. A wide range of physical symptoms and illness were reported including cancer, chronic back pain, chronic neck pain and coronary heart problems. Of those who had a physical illness prior to death, 38% were in physical pain in the year prior to death and 17% had reduced physical capabilities in the month prior to death. In addition to physical illness, 69.1% had been diagnosed with depression, and in terms of mental health comorbidity, 28.5% were diagnosed with an additional secondary psychiatric disorder, most frequently anxiety disorder, alcohol and drug dependence (Arensman et al., 2013). A more recent study of patients presenting to hospital with high-risk self-harm found that most (72%)

had chronic physical pain in the past year (Sadath et al., 2023). The study also reported that more than half had a recent reduction in physical capabilities (56%) and that 64% were taking medication for a physical illness.

Implications for safeguarding processes

Safeguarding and determination of a person's capacity to request hastened death has been highlighted as being particularly difficult for psychiatric patients and available frameworks are not always appropriate (Doernberg et al., 2016). A recent systematic review of determinants to implementing assisted dying processes identified a broad range of factors that exist on a spectrum, reflecting the complexity of the process. In particular, the review identified the lack of research on safeguarding processes within such frameworks (Byrnes et al., 2022). In addition, health inequalities, including variation in access to health services, are associated with premature mortality, including suicide, which would be an important aspect to consider in the assessment of requests for assisted dying (Arcaya et al., 2015).

While a Canadian study found that patients with psychiatric comorbidity were more likely to have a longer-standing wish to access assisted dying and to have had at least one assessment undertaken by a psychiatrist (Isenberg-Grzeda et al., 2021), Calati and colleagues' systematic review of psychiatric patients requesting assisted dying reported that more than two-thirds of patients not granted assisted dying had not died subsequently and more than one-third of requests were subsequently withdrawn. The review authors highlight important considerations, including medical futility, psychological understanding and decision-making capacity in psychiatric patients (Calati et al., 2021). This aligns with a more recent scoping review which found that the assessment of 'suffering' is often without clear structures, interdisciplinary teams and a focus on non-physical symptoms (Henry et al., 2023).

National Suicide Research Foundation
WHO Collaborating Centre for Surveillance and Research in Suicide Prevention
4.28 Western Gateway Building
University College Cork
Cork, Ireland

www.nsrf.ie
infonsrf@ucc.ie

November 8th,2023

References

Arcaya MC, Arcaya AL & Subramanian SV (2015). Inequalities in health: Definitions, concepts, and theories. *Global Health Action*, *8*. https://doi.org/10.3402/gha.v8.27106

Arensman E, Wall A, McAuliffe C, Corcoran P, Williamson E, McCarthy J, Duggan A & Perry IJ (2013). *National Suicide Research Foundation Second Report of the Suicide Support and Information System*. National Suicide Research Foundation. https://www.nsrf.ie/wp-content/uploads/2021/12/SSISReport2013.pdf

Byrnes E, Ross AI & Murphy M. (2022). A systematic review of barriers and facilitators to implementing assisted dying: A qualitative evidence synthesis of professionals' perspectives. *Journal of Death and Dying.* https://doi.org/10.1177/00302228221116697

Calati R, Olié E, Dassa D, Gramaglia C, Guillaume S, Madeddu F, & Courtet P (2021). Euthanasia and assisted suicide in psychiatric patients: A systematic review of the literature. *Journal of Psychiatric Research*, *135*, 153–173. https://doi.org/10.1016/j.jpsychires.2020.12.006

Canetto SS & McIntosh JL (2022). A comparison of physician-assisted/death-with-dignity-act death and suicide patterns in older adult women and men. *The American Journal of Geriatric Psychiatry*, *30*(2), 211–220. https://doi.org/10.1016/j.jagp.2021.06.003

Central Statistics Office (2022). Suicide Statistics 2019. https://www.cso.ie/en/releasesandpublications/ep/p-ss/suicidestatistics2019/ [Accessed 6th November, 2023]

Doernberg SN, Peteet JR & Kim SYH (2016). Capacity evaluations of psychiatric patients requesting assisted death in the Netherlands. *Psychosomatics*, *57*(6), 556–565. https://doi.org/10.1016/j.psym.2016.06.005

Doherty AM, Axe CJ & Jones DA (2022). Investigating the relationship between euthanasia and/or assisted suicide and rates of non-assisted suicide: Systematic review. *BJPsych Open*, *8*(4), e108. https://doi.org/10.1192/bjo.2022.71

Federal Statistical Office. (2016). *Cause of death statistics 2014. Assisted suicide and suicide in Switzerland*. https://www.bfs.admin.ch/asset/en/3902308 [Accessed 7th November 2023].

Girma S & Paton D (2022). Is assisted suicide a substitute for unassisted suicide? *European Economic Review*, *145*. https://doi.org/10.1016/j.euroecorev.2022.104113

Henry M, Alias A, Bisson-Gervais V, Liu JY, Dargis L, Gauthier L, Tapp D, Greenfield B, Mishara B (2023). Medical assistance in dying in Canada: A scoping review on the concept of suffering. Psycho-Oncology. *232*(9), 1339-1347. https://doi.org/10.1002/pon.6196

Isenberg-Grzeda E, Nolen A, Selby D & Bean S (2021). High rates of psychiatric comorbidity among requesters of medical assistance in dying: Results of a Canadian prevalence study. *General Hospital Psychiatry*, *69*, 7–11. https://doi.org/10.1016/j.genhosppsych.2020.12.017

Mitchell AJ, Vaze A & Rao S (2009). Clinical diagnosis of depression in primary care: A meta-analysis. *The Lancet*, *374*(9690), 609–619. https://doi.org/10.1016/S0140-6736(09)60879-5

Nafilyan V, Morgan J, Mais D, Sleeman KE, Butt A, Ward I, Tucker J, Appleby L & Glickman M (2023). Risk of suicide after diagnosis of severe physical health conditions: A retrospective cohort study of 47 million people. *The Lancet Regional Health – Europe*, *25*. https://doi.org/10.1016/j.lanepe.2022.100562

Posner R. (1997). *Aging and old age*. University of Chicago Press.

Sadath A, Troya MI, Nicholson S, Cully G, Leahy D, Ramos Costa AP, Benson R, Corcoran P, Griffin E, Phillip E, Cassidy E, Jeffers A, Shiely F, Alberdi-Páramo Í, Kavalidou K & Arensman E (2023). Physical and mental illness comorbidity among individuals with frequent self-harm episodes: A mixed-methods study. *Frontiers in Psychiatry*, *14*. https://doi.org/10.3389/fpsyt.2023.1121313

Steck N, Egger M & Zwahlen M (2016). Assisted and unassisted suicide in men and women: Longitudinal study of the Swiss population. *The British Journal of Psychiatry*, *208*(5), 484–490. https://doi.org/10.1192/bjp.bp.114.160416