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Subject: VAD Submission - M Coughlan
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Dear Committee Secretariat,

Please find below Australian Regional and Remote Community Services' (ARRCS) submission to the Legal and Constitutional Affairs Committee's Inquiry into Voluntary Assisted Dying (VAD) in the Northern Territory.

Name: Michael Coughlan

Organisation: Australian Regional and Remote Community Service (ARRCS)

Postcode: [REDACTED]

Submission to the Inquiry into Voluntary Assisted Dying

Firstly, thank you for the opportunity to make a submission to the Legal and Constitutional Affairs Committee on this subject of Voluntary Assisted Dying (VAD). My comments are from my own perspectives as an Aboriginal man with over 35 years experience working in senior roles in Aboriginal Community Relations and Community Development across private, public, not for profit and community organisations. I also hold a Masters Degree in Business Administration and a Masters Degree in Aboriginal Affairs. This submission should also not be taken as a position on VAD by Australian Regional and Remote Community Services' (ARRCS). I currently work for ARRCS as their Executive Manager - First Nations Programs and I was encouraged by the committee to make a submission following their public consultation held at the Old Timers Village in Alice Springs. A little background on ARRCS, their work began in 2014 with aspirations to improve the quality of life for people living in regional and remote areas of Australia. Today, our commitment remains stronger than ever. In the Northern Territory we provide support to elderly Aboriginal and Torres Strait people from Darwin, Katherine, Tennant Creek, Nhulunbuy, Alice Springs, Mutijulu and Kaltukatjara (Docker River) through aged care services, childcare and regional home care services, residential aged care, school nutrition programs. Moreover, ARRCS supports Aboriginal and Torres Strait Islander people from remote areas outside of these centres. We recently expanded into the APY Lands of South Australia and are looking at the feasibility of providing aged care services there. We have a dedicated Aboriginal and Torres Strait Islander Team, which consists of several key programs teams such as the Careers Team, Cultural Specialist Team, a RAP Specialist and the Return to Country Team who ensure a collaborative approach across ARRCS. Our approach is embedded in a framework of deep respect for cultural care, kinship, country, cultural traditions, cultural beliefs and cultural activities. There are occasions where we already provide full wrap

around support to elders dying (where they are aware they are dying) in our facilities or where they return home (return to country) for other purposes.

Do you support making VAD legal in the NT?

The national Aged Care Standards state that every older person including Aboriginal and Torres Strait Islander people should have the right to make informed decisions about their care plans. In fact, the rights of the individual is central to the 8 National Quality Aged Care Standards. In an Aboriginal and Torres Strait Islander context, this would seem to naturally extend to the right for a person to decide to make a voluntary decision to die. Currently there is a legislative gap where an Aboriginal and Torres Strait Islander person has made up their mind to die. At the risk of generalising, it is not uncommon within our culture to decide to die because of health or other reasons and can and do will ourselves to die. When this occurs, and while the individual can still exercise choice, a choice can be made to return to country to die and thus leave the care of our facilities, or for that matter choose to stay and pass away in the facility which is generally not favoured. In such cases our Return to Country Team (RTC) will ensure that person's care plans are paramount, that there is good communication and support from the family, health practitioners and or services, and our team will accompany the person on their journey home. In our experience, Aged Care Service Site Managers may be cautious of supporting a return to country if the person is a risk of not returning, because they are mindful of ARRC's duty of care obligations, although a decision to return to care will ultimately rest with the individual, it still does create a dilemma. Having legislation in place, may make clearer the responsibilities in such cases.

What eligibility criteria should a person need to meet before they can access VAD?

Eligibility criteria should contain at minimum the key elements consistent across national jurisdictions as outlined in the consultation paper, such as:

A minimum age provision, residency, suffering, prognosis, and decision-making capacity.

A process for independent assessment of eligibility by two qualified and experienced health practitioners.

The administration of substance prescribed by a doctor, either via self-administration or administration by a health practitioner on the person's request.

A conscientious objection by health practitioners who do not wish to participate in VAD and accountability by oversight provisions, including reporting, monitoring by an oversight body and compliance enforcement.

In addition, any VAD guidelines and regulations should contain provisions for culturally appropriate Aboriginal and Torres Strait Islander care plans, including return to country support. Family or individuals should also have the right to a

conscientious objection. In some instances, family members or communities may not wish to be involved due to beliefs around “black magic” or perceived “payback” repercussions. These matters need to be explored during the RTC care plan.

Here in the Northern Territory, cultural reasons for wanting to end your life may need to be a consideration as well, I do not believe this is covered in other States or Territories legislation or being considered under any legislation here in the Northern Territory.

How could the NT ensure safe and equitable access to VAD, especially for remote and Aboriginal people?

It is acknowledged that equitable access is a key issue in the Northern Territory due to geographic, demographic, economic and other factors. To ensure equitable access to VAD in remote communities and for Aboriginal and Torres Strait Islander people requires investment in fit for purpose technology, infrastructure and resources. Resources should include tapping into and working closely with Aboriginal Community Controlled Health Organisations (ACCHOs), Community Health Services, Aged Care providers, health professionals, other service providers and particularly providers with a comprehensive Return to Country program that is consistent with the individual’s care plan. However, in many cases these service providers may already be operating at maximum capacity, therefore any VAD model needs to be mindful not to overload these services or impact negatively on their ability to continue their current services. In any case, at minimum, equity may be achieved by ensuring that the VAD care plan has been informed by and supported by the necessary cultural expertise relevant for the individual. In terms of ARRCS, we fund some of our Return To Country activities under the Commonwealth Home Support Programme (CHSP), while the remainder is funded from ARRCS’s general revenue. If a VAD Return to Country was required it would need to be 100% funded by ARRCS’s own revenue, because CSHP cannot be used for people with intensive, multiple or complex needs, or permanent residents of aged care residential facilities, as such a VAD RTC country would need to be assessed on a case by case basis and subject to available funds unless VAD specific funding support was available. Another consideration may be related to family support during the VAD process, and post sorry business ceremony.

4. How could the NT monitor the process to ensure VAD is delivered safely and effectively?

There should be a co-management body consisting of representatives from each of the key stakeholders to ensure that all views and cultural nuances are covered. Regulations can underpin this body and its role. This could be combined with an authority that is informed by such a stakeholder body. The regulations and or guidelines should include a framework which covers the monitoring of implementation, a cycle of planning, review/assessment, adaptation/improvement/adoption, continued implementation, and compliance enforcement. The framework could be in shorter cycles during implementation and move to longer timeframes as the model is refined.

5. Additional Comments:

Ultimately, VAD is a facility that individuals may or may not take up, it is inherently an individual's choice.

There are many cultural nuances when it comes to Aboriginal people and Aboriginal and Torres Strait Islander people themselves because we are not a homogenised group, the NT legislation would be well advised to seek out expert advice/support from those working in these spaces already and within Government.

Holistic training should be considered for VAD support workers. There is a nationally accredited certificate IV titled "End of Life Doula Course". Also what other supports might be needed for VAD support workers should be considered.

The committee could also view the following resource from the Aged Care Commission, it features ARRC's employees, residents and ARRC's approach is in the embedded videos [aged-care-quality-and-safety-commission-first-nations-resources-communications-toolkit-june-2025.pdf](#)

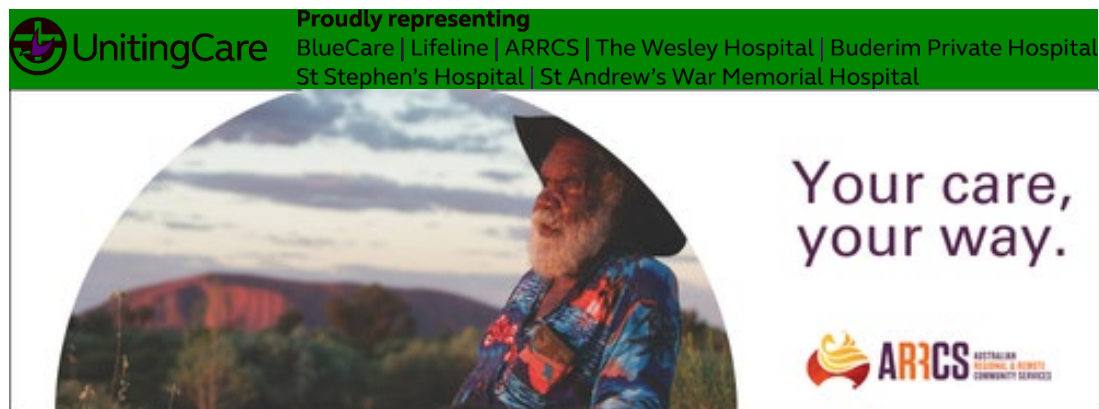
Lastly, if a two doctor approval process is adopted, how will the cultural integrity of those approvals be assured? The cultural fit of any Northern Territory legislation can and will be undermined by any lacking in a cultural standards framework.

Kind Regards

Michael Coughlan

Executive Manager - First Nations Programs
First Nations

[Redacted]
Street Tiwi NT 0810
PO Box 43021, Casuarina, NT 0811
arcs.org.au



ARRC respectfully acknowledge the Traditional Custodians of the lands on which we work and live and connect to Australia's First Nations Peoples. We acknowledge Elders both past and present, whose ongoing effort to protect and promote Aboriginal and Torres Strait Islander cultures will leave a lasting legacy for future leaders and reconciliation within Australia.