Katie Helme – Committee Secretary
Legal and Constitutional Affairs Committee
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By email: LA.VAD@nt.gov.au

29th of August 2025

Dear Legal and Constitutional Affairs Committee,

The Australian Christian Lobby (ACL) is grateful for the opportunity to provide this submission to the Inquiry into Voluntary Assisted Dying.

This submission is approved at ACL's national organisation level.

Thank you for giving our submission your careful consideration.

Yours Faithfully,

Nicholas Lay
NT Director, Australian Christian Lobby
0870

# Submission to the Inquiry into Voluntary Assisted Dying NT

## AUSTRALIAN CHRISTIAN LOBBY

## About Australian Christian Lobby

The vision of the Australian Christian Lobby (ACL) is to see Christian principles and ethics influencing the way we are governed, do business, and relate to each other as a community. ACL seeks to see a compassionate, just and moral society through having the public contributions of the Christian faith reflected in the political life of the nation.

With around 250,000 supporters, ACL facilitates professional engagement and dialogue between the Christian constituency and government, allowing the Voice of Christians to be heard in the public square. ACL is neither party-partisan nor denominationally aligned. ACL representatives bring a Christian perspective to policy makers in Federal, State and Territory Parliaments.

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**Clarification of Language**

The Australian Christian Lobby (ACL) opposes the euphemistic term "Voluntary Assisted Dying" (VAD). We believe this is an attempt to reshape perceptions around ending one's life through suicide. During our submission we will refer to VAD as Assisted Suicide (AS). We believe this more accurately described the act being discussed. Accurate terminology is important when discussing complex legal and ethical frameworks around end-of-life[1].

**Concerns Regarding Legal Advisor Appointment**

It is highly concerning that Professor Ben White has been appointed as legal advisor to the Legal and Constitutional Affairs Committee and to provide drafting instructions for this inquiry. Particularly given that, in accordance with 5. of the Terms of Reference, "*If the Committee recommends adoption, provide drafting instructions for model legislation to give effect to voluntary assisted dying in the NT",* it is up to the Committee to recommend whether or not drafting instructions are required and this outcome should not be pre-determined.

Professor White is a well-known advocate for Assisted Suicide and is currently leading a research project at the Queensland University of Technology (QUT)[2] to *"further the evidence-base on Voluntary Assisted Dying for people with dementia", "identify possible legislative models that could allow for access to VAD for people with dementia"* and "*provide a basis for informed Australian public policy debates and law reform deliberations"*.

It is concerning that our Assisted Suicide laws in the NT are being drafted by an entrenched pro-Assisted Suicide advocate who is leading the charge for dementia patients (who cannot provide consent) to have access to Assisted Suicide in Australia, rather than someone impartial. Professor White's appointment was also made before any public consultation had taken place.

We also note that Professor White made a submission[3] to the same inquiry he is providing legal advice to, which at least appears to be a clear conflict of interest and influencing the outcome of the consultation and process. An interstate advocate providing input and output either side of an inquiry designed to do more community consultation with Territorians appears highly improper.

## Consultation Topic 1: Legislating VAD in the NT

Question 1: Do you support legislating VAD in the NT? Why or why not?

**We are opposed to Assisted Suicide and urge the Committee to recommend against legislating Assisted Suicide in the NT for the following reasons:**

**1. Each human life is precious and has value.**

ACL aligns strongly with the foundational Christian belief in the value of every human life. The introduction of Assisted Suicide would represent a significant change and a lack of respect for human dignity. Legalising Assisted Suicide requires more than a simple change to the law. It represents a paradigm shift from an ethical and legal framework that declares the deliberate taking of life by private citizens (including medical professionals) as morally insupportable in absolute terms to one which allows relative and circumstantial evaluations to be made about different lives on a case-by-case basis. Assisted Suicide can only be contemplated by putting aside the current legal recognition

[1] Carr v Attorney-General (Cth) [2023] FCA 1500

[2] https://research.qut.edu.au/vad-and-dementia/

[3] https://parliament.nt.gov.au/committees/list/legal-and-constitutional-affairs-committee/VAD/submissions/Submission-No.-5-Professor-Ben-White-and-Professor-Lindy-Willmott.pdf

of the unique and infinite value of the human person, to instead embrace the acknowledgment that some lives are not worth living.
In the 2021 census, it was recorded that 94,151 Territorians identified as some form of Christian, representing 40.5% of the NT population[4]. The Australian Christian Lobby aims to represent fundamental Christian values in what we advocate for.

**2. Assisted Suicide is State sanctioned killing that should be rejected entirely.**
Involving the health system and governments in Assisted Suicide is state sanctioned killing. We should never involve the government in ending people's lives no matter how much an individual wants it.

This will inevitably de-value Australian lives, particularly those of our old, disabled and sick. It's a contradiction to offer emotional and physical support to endure the final days while on the other hand, also offering the option to not endure.

Having the availability of Assisted Suicide will devalue human life, the ramification of that will be shown over time. Over the course of history and even today, human life can easily be devalued leading to devastating situations.

If the NT parliament permits Assisted Suicide, it will set us on a dangerous path. In some other jurisdictions where Assisted Suicide has been legal for a longer period, access for children, and for disability, mental health and dementia reasons has eventuated.

Belgium[5] and the Netherlands[6] have laws permitting children to access Assisted Suicide. Canada allows for irreversible disability and mental health reasons[7]. The Netherlands allows for dementia patients or patients that have lost decision making capacity through an advanced directive[8]. This has led to at least one horrible account of an elderly woman specifically refusing Assisted Suicide when the time came. The doctor placed a sedative in her coffee without her knowledge and she was held down against her will by family members to be put to death. The women physically fought off the attempt to be killed but was unfortunately unsuccessful[9].

**3. Significant opposition noted amongst aboriginal people.**
In the Northern Territory we have conducted our own consultations with aboriginal people in urban areas and out bush over a number of years. Overwhelmingly, we have observed opposition to the introduction to Assisted Suicide laws in the NT.

Here are some of the conversations we had across the Northern Territory:

- Summary video: https://youtube.com/shorts/X4LViXRZnBo?si=WaiUCnoNmQwM5kLo
- Malcolm Heffernan – Arrernte elder (Araluen/Braitling/Gwoja Electorate): https://youtube.com/shorts/wvdzsMvTveU?si=oaOdwSL8yaSjVKBO
- Sherry Lowah - Arrernte/Luritja/Pitjantjatjarra/Torrest strait islander (Araluen/Braitling/Gwoja Electorate): https://youtube.com/shorts/Z0rwinavIFI?si=ywa-HoxXvHIxwxlX
- Yolngu (Mulka Electorate) - Brenda Muthmuluwuy, Rev. Ken Garrawurra, Rev. Alfred Dywany

[4] https://profile.id.com.au/rda-northern-territory/religion
[5] https://oneill.law.georgetown.edu/child-euthanasia-in-belgium/
[6] https://www.government.nl/topics/euthanasia/is-euthanasia-allowed
[7] https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html
[8] https://www.government.nl/topics/euthanasia/is-euthanasia-allowed
[9] https://www.dailymail.co.uk/news/article-4166098/Female-Dutch-doctor-drugged-patient-s-coffee.html

Dyjwany Gondarra and Harry Garrawurra: https://www.youtube.com/watch?v=6LZ6W2IGFoA
- Serena Presley – Anmatyerr (Barkly Electorate) : https://www.youtube.com/shorts/Z_wuGzq-Xkk
- Nathaniel Dixon/Morton & Savior George (Gwoja Electorate) – Anmatyerr: https://youtube.com/shorts/BNnlPTUH7R8?si=IKZJ3bmDGvnJv-Lk

Dr Kane Vellar appeared before the committee as a witness for NT Health on the 5th of August 2025 and said, *"in our consultations, we did experience a lot of pushback in remote traditional settings"*[10].

**4. The cost to the public health system does not justify any benefits; The funds could be better used.**

In the NT, the Government of the day has a monumental task to manage a range of basic services such as healthcare, education, policing, corrections and courts among other important portfolios with such a scattered population over a large land area. In the NT, we don't have the luxury of some of the basic healthcare services, and funding for Assisted Suicide should not be prioritised. To think that we would divert healthcare workers' time away from providing essential healthcare to life ending services is simply irresponsible. People may want the "choice" to end their life, but at what cost? For someone to have "choice", someone else will be left to wait and in need of essential healthcare or to never get the care they need. It's an awfully high price to pay so that people can have the choice.

We are told that overwhelmingly people want the choice to access Assisted Suicide. Based on other States in Australia, we know that statistically a very small percentage of people actually use the Assisted Suicide substance to end their life. An estimate of 10-12 people per year was provided by NT Health during public consultation on the 5th of August 2025[11].

We interviewed the Hon Robyn Lambley MLA on the issue of Assisted Suicide and based on her experience in Parliament and as a past Deputy Chief Minister, she estimated that the recommended scheme would cost $10 million dollars a year[12]. If this estimate is accurate and the estimate of 12 is accurate, that equates to $833,333.33 per death. That would be exorbitant, and the opportunity cost, unjustifiable.

If the committee proceeds with providing drafting instructions, we highly recommend including estimated costs and undertaking a full cost-benefit analysis before legislating so that Territorians and all parliamentarians can be fully informed about the financial cost of Assisted Suicide before it goes to a vote in Parliament. We also highly recommend, once the oversight board is established, that the full annual budget and actual costs associated with all aspects of Assisted Suicide in the NT are proactively released to the public.

**5. Negative health impacts on aboriginal people.**

Anecdotally we have heard many reports that Assisted Suicide would create fear and blame throughout aboriginal communities. This is not well documented but is obvious to those that have experience living in or working with aboriginal communities.

[10] See page 37 of: https://parliament.nt.gov.au/__data/assets/pdf_file/0019/1552123/Hearing-Transcript-Tuesday-5-August-2025.pdf
[11] See Page 30 of https://parliament.nt.gov.au/__data/assets/pdf_file/0019/1552123/Hearing-Transcript-Tuesday-5-August-2025.pdf
[12] Watch https://youtu.be/E4BqTHLM9sc

The member for Mulka, Mr Yingiya Mark Guyula, said in Parliament when discussing Assisted Suicide: *"Beliefs in our culture mean that voluntary assisted dying could create fear and blame throughout our communities. If someone dies early, there could be blame placed on the family that this has happened. There is also fear of the health system generally. When family members have been sent to hospital for care and never returned, our communities worry about what has happened and whether they died naturally, and that they have died without ceremony. These issues in our community create fear about VAD[13]."*

Aboriginal leaders also told the Panel in the initial consultation that *"There has always been fear in our community about going into hospital or going to Darwin when you are sick, because you will probably not return home"*[14]

Aboriginal people living in remote communities are adversely impacted by chronic health issues[15]. Another barrier to providing health services to aboriginal people in the NT is not needed.

**6. The elderly may be vulnerable to fatal elder abuse in the context of Assisted Suicide.**

Awareness of elder abuse is increasing, and there are added risks in relation to assisted suicide including:

- Explicit or implicit pressure: Explicit or implicit pressure from family members or caregivers suggesting or implying that an older person is a burden (physically, emotionally, financially, etc.), because the abuser stands to benefit in some way from the person dying.
- Financially motivated actions: Family members may be motivated by prospects of inheritance or concerns about an elderly person's estate and thereby encourage them to opt for Assisted Suicide.
- Isolation and neglect: Adequate emotional support or physical care may be withheld from older individuals by caregivers, either deliberately or through neglect, so older people feel that Assisted Suicide is the only dignified option for them or that death may be a relief.
- Medical and institutional influence: Healthcare workers such as doctors, nurses or palliative care providers may present Assisted Suicide as a preferable choice without sufficiently exploring palliative care options or alternative supports. They may also influence decisions to undertake Assisted Suicide due to personal bias or as a result of systemic pressure to efficiently manage healthcare resources.

Terminally ill older people may be particularly vulnerable to such pressures, given their likely physical frailty and/or cognitive decline, social isolation, and dependence on family or caregivers.

**Statistics regarding elder abuse which highlight the risk factors connected to Assisted Suicide particularly**

- The Australian Institute of Health and Welfare ('AIHW') published statistics about older people and family, domestic and sexual violence on 28 February 2025.[16] One key finding in the AIHW publication includes that 1 in 6 (15% or 598,000) older people in Australia had experienced elder abuse in the past year. According to the published AIHW statistics:
    - Family members as perpetrators: 1 in 2 perpetrators are a family member. In our view, this may suggest a particular vulnerability of Assisted Suicide schemes to elder abuse,

[13] https://territorystories.nt.gov.au/10070/997778
[14] See 3.2 Opposition to VAD in the NT Voluntary Assisted Dying Final Report 2024
[15] See Appendix 4 of NT Voluntary Assisted Dying Final Report 2024
[16] See this publication by the Australian Institute of Health and Welfare on 28 February 2025: https://www.aihw.gov.au/family-domestic-and-sexual-violence/population-groups/older-people

given that family may have particular personal or financial motivations to coerce other members into considering Assisted Suicide.

- Carers as perpetrators: The AIHW statistics did also acknowledge that elder abuse can also occur through paid carer relationships, and in aged care facilities and health care services, both environments which may also be especially relevant to Assisted Suicide schemes (particularly health care services).
- Psychological abuse: Psychological abuse is the most common form of elder abuse (12% had experienced this in the past year). In our view, this highlights that older people are particularly vulnerable to the sort of elder abuse which may occur in respect of Assisted Suicide – i.e. a psychological form of abuse such as coercion which is acknowledged as a key possibility in the QLD Assisted Suicide Act.
- Financial and physical abuse: The statistics reveal that 2.1% of older Australians had experienced financial abuse in the past year, and 1.8% physical abuse. These less common acts may also be relevant to Assisted Suicide, where family members may seek to hasten an older person's death for financial benefit, or where any involved person may be part of physically forcing a person to ingest an Assisted Suicide substance.
- Disability and illness: The AIHW indicated that some studies suggest that older people with disability may be at increased risk of elder abuse. For example, one study showed that 21% of older people with disability or long-term health conditions had experienced elder abuse in the past 12 months. In fact, older people with a disability or long-term health conditions experienced higher rates of *every* type of elder abuse than older people without such disability or conditions. Such reports clearly suggest the particular susceptibility of Assisted Suicide schemes to instances of elder abuse. With eligibility for Assisted Suicide being tied to a person being diagnosed with a disease, illness or medical condition that is advanced, progressive and expected to cause death within a time period, *the cohort of people eligible for Assisted Suicide are also the very cohort at increased risk of elder abuse of every type.*

**Examples of sources which clearly suggest a link between Assisted Suicide and elder abuse and advocate for preventative measures**

- Academic and industry sources suggest a direct link between Assisted Suicide schemes and elder abuse, and which advocate for preventative measures. For example:
  - A study published in the *Macquarie Law Journal* in 2018 about "the nexus between elder abuse, suicide, and assisted dying"[17] advocated that with the legalisation of Assisted Suicide, there is "an urgent need to discuss the potential implications of such legislation for elder abuse". It clearly acknowledged that Assisted Suicide decisions may be "potentially an extreme form of elder abuse", and the fact that older people "may be particularly vulnerable to abuse under this legislation" including because of their interpersonal contexts, dependent relationships, health burden and perceived burdensomeness influencing their decision making. It discusses this 'nexus' in great detail.
  - The Australian Care Alliance (a group of health professionals, lawyers and community activists who informally worked together to oppose Assisted Suicide in Victoria[18])

[17] See a copy of Macquarie Law Journal study on the AustLii website here: https://www.austlii.edu.au/cgi-bin/viewdoc/au/journals/MqLawJl/2018/6.html. See also a copy apparently also published on the NSW Parliament website: https://www.parliament.nsw.gov.au/lcdocs/other/16516/The%20Nexus%20Between%20Elder%20Abuse%20tendered%20by%20Professor%20Carmelle%20Peisah.pdf

[18] See this page about the Australian Care Alliance: https://www.australiancarealliance.org.au/about.

asserts[19] a "real and substantive" risk of elder abuse regarding Assisted Suicide as demonstrated by reported statistics similar to the above.

- In fact, there are also sources that point to real cases in which coercion regarding Assisted Suicide may have occurred. In particular, a study published in the *National Library of Medicine* in 2023,[20] which broadly discussed euthanasia in various jurisdictions, contained a paragraph about the submission of Professor David Kissane, an Australian psychiatrist specialising in psycho-oncology and palliative care, to the *Inquiry into the provisions of the Voluntary Assisted Dying Bill 2021* in New South Wales. According to the study, he shared de-identified stories of patients, including one who "was reported to have been pressurised to" euthanasia by an adult child home on holidays, and a case in which the oncologist referred a patient to a psychiatrist (who diagnosed clinical depression), although the patient's family "were encouraging the patient to request" euthanasia.
- These sorts of sources also indicate a link between elder abuse and Assisted Suicide.

**7. The argument concerning 'personal choice' is a flawed one.**

The argument always immediately arises that those who disagree with Assisted Suicide can choose not to access Assisted Suicide, so why stop others from accessing it?

The difference with Assisted Suicide is that there would be involvement of the Government, the health system and our tax dollars to provide Assisted Suicide to Territorians.

In a democracy, we have avenues to advocate for what we believe the Government of the day should do with the power and responsibility placed upon them. It is because of this that we advocate for the Government to completely reject Assisted Suicide.

**8. Territorians did not vote for Assisted Suicide.**

The NT election was only a year ago, where Territorians were given the option of a Labor Government who had committed to drafting legislation for Assisted Suicide and the Country Liberal Party who made no commitments to it outside of a conscience vote to party members if a bill should arise. This was at the peak of the debate as the report from the previous consultation was published a month before the election. It's clear that Territorians don't see this as a priority and they voted for the party that made no commitments to introduce Assisted Suicide.

**9. "Specialist Palliative Care…supports a dignified death".**

As written in the NT Voluntary Assisted Dying Final Report 2024[21], this bold assertion made by the panel contradicts the attempts to legislate Assisted Suicide to "die with dignity". To suggest that a dignified death can be found in Assisted Suicide is disrespectful to those that have died naturally who did die with dignity.

**Due to the reasons given above, The Australian Christian Lobby strongly opposes Assisted Suicide and opposes recommendation 1 from the 2024 report that "The NT should implement VAD legislation that is broadly consistent with VAD legislation in other Australian States and Territories".**

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[19] See Australian Care Alliance website regarding 'New Report on Elder Abuse in Australia: Implications for Legalising Euthanasia': https://www.australiancarealliance.org.au/new_report_on_elder_abuse_in_australia_implications_for_legalising_euthanasia.

[20] See a copy of the study on the National Library of Medicine website here: https://pmc.ncbi.nlm.nih.gov/articles/PMC10808165/.

[21] See page 52

**The next 59 questions in this consultation relate to how Assisted Suicide should be implemented if it is implemented.**

**We provide these remaining submissions in the event that the Government progresses with legislating Assisted Suicide.**

Question 2: What aspects of VAD legislation in other States or Territories do you think should or should not be adopted in the NT?

Whilst we are opposed to Assisted Suicide, if any legislation is adopted, the NT should adopt the South Australian Voluntary Assisted Dying legal framework around individual and organisational conscientious objection rights, the relevant provisions are included in Appendix A.

Question 3: Given the NT's unique cultural and geographic circumstances, what additional or different safeguards should be included?

Assisted Suicide should not be available in remote or regional communities. It should also not be available via Telehealth if Federal Laws are changed, due to the high risks of elder abuse and coercion.

## Consultation Topic 2: Delivering VAD in the NT

Question 4: What are the benefits or challenges you see with a stand-alone VAD service operating separately from existing NT Health services?

It would help distinguish between lifesaving care and life ending services.

Question 5: How can we make sure people in remote or regional communities can access VAD fairly and safely if they wish?

Assisted Suicide should not be available in remote or regional communities. The implementation of assisted suicide through Telehealth is currently illegal and should not be contemplated due to high risks of elderly abuse[22]. It is impossible for a doctor on a Telehealth call to understand or see if coercion or elder abuse is occurring.

Patients that are end of life, will inevitably end up in either Darwin or Alice Springs for palliative care services. Assisted Suicide should only be available in these locations. It would be inconsistent and ethically wrong to offer Assisted Suicide services in remote communities when there is a lack of palliative care services outside of Darwin and Alice Springs.

If there is more funding and resourcing available for remote communities, it absolutely needs to be put towards lifesaving health care. It is unethical to offer easy access to Assisted Suicide in remote and regional communities and not offer palliative care in the same location. If there is ease of access to Assisted Suicide in remote and regional communities and not palliative care, it could manipulate people to access Assisted Suicide. This would be systematic coercion.

In the NT Voluntary Assisted Dying Final Report 2024 it discussed interpreters using Telehealth[23] to translate. This should be specifically prohibited as interpreters need to understand the full context of a room to be able to translate accurately and rule out coercion or elder abuse.

[22] See note 1 above.
[23] See page 65

**Due to the above reasons, we oppose recommendation 13 from the Voluntary Assisted Dying Final Report 2024. The recommendation is listed below.**

*RECOMMENDATION 13*
*Subject to amendment of Commonwealth legislation, telehealth should be permitted for VAD purposes provided at least one assessment is conducted in person.*

Question 6: How could a VAD system be built in a way that is respectful and sensitive to past experiences and trauma of Aboriginal and Torres Strait Islander people if there is support for VAD in the community?

By not legislating Assisted Suicide. Alternatively, if the NT has a separate, centralised service, Assisted Suicide staff should not leave Alice Springs or Darwin (to remain as an alternative to palliative care not in lieu of palliative care).

Question 8: How can communities report concerns or feedback in a culturally safe and confidential way?

We believe there should be mandatory reporting requirements placed on health staff when they encounter patients that are suspected to be averse to and refuse standard lifesaving healthcare because of fear of Assisted Suicide. This would hopefully be an accurate way to document the impact of Assisted Suicide on the healthcare system, which can inform high level decision making around Assisted Suicide. In abiding by this requirement, we recommend the following standard.

If a patient presents to a health practitioner for any medical reason and both of the following are met,

1. The patient refuses to follow through with any of the following: the consultation, examination, medication, further consultations or healthcare; and
2. The health practitioner reasonably suspects that it is due to patient concerns about the existence of Assisted Suicide services.

Then the health practitioner should be legally required to report to the VAD Review Board. This should include the following information:

- What treatment was refused.
- The diagnosis/health condition or suspected diagnosis of the patient.
- What the potential negative impact this may have on the patient for refusing further healthcare.
- Why the health practitioner reasonably suspects refusal is due to the existence of Assisted Suicide services.
- Date of refusal.

## Consultation Topic 3: Eligibility

Question 10: Should 18 years be the minimum age for accessing VAD? Why or why not?

An individual must be at least 18 years old to be eligible for Assisted Suicide.

Question 12: What specific exemptions may be needed for Aboriginal or Torres Strait Islander individuals who want to return to the NT to finish up on Country?

None, it should only occur in Darwin or Alice Springs in the same towns as palliative care access.

Question 13: Is a 12-month prognosis an appropriate timeframe for eligibility for VAD? Should it be shorter or longer?

No, 12 months is too long as the patient's prognosis is uncertain, so they may survive much longer. The timeframe should be limited to within weeks of certain death.

The initial pitch for Assisted Suicide in Australia was so that those people in the end-of-life stages would be able to end their inevitable suffering prematurely. Even a 6-month prognosis is already quite excessive when considering that scenario. On the Victorian Department of Health's webpage "The last twelve months of life[24]", it states that a:

- **12 months** prognosis" actually means that the prognosis is "**uncertain**".
- A "**weeks to months**" prognosis means the prognosis is **12 months** and an
- "**imminent**" prognosis means "**hours to days**".

The advocates for Assisted Suicide often speak of relieving suffering in those final stages of life, an uncertain diagnosis (12 months) is well outside that need. A 6-month diagnosis is also difficult to predict. Allowing access to Assisted Suicide when given a 12-month prognosis is way too broad. This is verified in Victoria Health's definition of a 12-month prognosis, which would likely be similar in the NT, actually means that they are "uncertain" of how long the patient will live. This will give access to patients who may not actually be going to die anytime soon or could recover.

76% of eligible applicants in the Victorian Assisted Suicide scheme had a cancer diagnosis[25]. Cancer generally leaves a patient with high functionality for a longer period of time, often physically able to continue activities that they were able to before the cancer diagnosis (outside of treatment) and they will have a rapid decline usually in a two-month period leading into death. It's this two-month period that is used to justify the need for Assisted Suicide particularly in cancer patients[26].

Palliative care hospitalisations are a good metric to help understand those who are experiencing suffering and pain because of a terminal illness. The window of unbearable suffering (requiring hospitalisation) due to a person's life-threatening illness is often incredibly short. In 2022-2023 the average length of stay for an overnight hospitalisation in palliative care was 11 days, almost 60% ended with the patient dying[27].

**It is for the above reasons that we oppose recommendation 10 in the 2024 report which is provided below.**

*RECOMMENDATION 10:*
*To access VAD in the NT, a person should have a serious and incurable condition which is causing intolerable and enduring suffering that cannot be relieved in a manner they feel is acceptable.*
*VAD eligibility shall be based on a prognosis of 12 months at the time of being assessed, irrespective of diagnosis and if the patient meets all other requirements.*

## Question 14: How should suffering be defined in the context of VAD eligibility?

Even though we disagree with Assisted Suicide, if it was legalised, it should only be for "Serious and incurable condition which is causing intolerable and enduring physical suffering that cannot be relieved…" However, "in a manner they feel is acceptable" is highly subjective and is often

[24] https://www.health.vic.gov.au/patient-care/the-last-twelve-months-of-life
[25] https://assets.nationbuilder.com/gogentleaustralia/pages/3038/attachments/original/1723682650/GGA_StateOfVAD_Report_2024_DIGITAL_Aug24.pdf?1723682650
[26] https://goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf
[27] https://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia/contents/summary

heightened by other emotional or spiritual aspects that could be relieved by psychological or pastoral support.

Question 15: How can we ensure that people with progressive diseases are protected but also treated fairly as part of a VAD framework?

Eligibility should be "Serious and incurable condition which is causing intolerable and enduring physical suffering" with a 'within weeks' prognosis.

Under 2.4 Clinical guidelines of the *NT Voluntary Assisted Dying Report 2024,* it said *"The Panel concluded the response of an assessing practitioner in cases of uncertainty should be left as a matter for professional clinical judgement rather than imposing legislative mandates".* The conversation around legislating Assisted Suicide depends heavily on "the right to die". If we were to legalise without robust eligibility criteria, doctors would feel pressured to approve Assisted Suicides as they would be impinging upon the patient's "right". This is a complex and new area of practice in Australia and strictly defined legislative eligibility is required.

Question 16: What support is needed to assess a person's capacity to make decisions about VAD?

**Comprehensive Palliative Care as a Prerequisite for Assisted Suicide Eligibility:**

Eligibility criteria should ensure that individuals are ineligible for access to Assisted Suicide unless they have been informed about palliative and given a prognosis of 'within weeks'.

**Mandatory Mental Health Assessment for Assisted Suicide Request:**

The eligibility criteria must ensure individuals undergo a mental health assessment by a psychiatrist within the month before making a first request. This assessment ensures that the person is not suffering from any undiagnosed mental illness or distress that may be influencing their request for Assisted Suicide.

**Implementation of Cooling-Off Period in Assisted Suicide Legislation:**

Legislation must incorporate a mandatory cooling-off period of 7 days before a person can self-administer or have administered an Assisted Suicide substance. This period allows an individual to reflect on their decision and provides some protection that it is made voluntarily without external pressure.

## Consultation Topic 4: VAD Process

Question 19: Who should be permitted to be a person's coordinating or consulting practitioner? For example, a registered medical practitioner, a nurse practitioner, or someone else? How many years of medical experience should they have?

Only registered medical practitioners possessing the necessary expertise and training should be entrusted with advising a patient on the expected course of their condition, on Assisted Suicide and palliative care options. They should also have a minimum of five years specialist registration prior to being eligible to provide assisted suicide. Their medical knowledge and experience and professional association requirements ensure a thorough evaluation of the individual's condition and capacity to make informed decisions regarding end-of-life care options and the provision of all relevant information to make an informed decision.

Question 20: Which health practitioners should be able to administer the VAD substance? For example, a registered medical practitioner, a nurse practitioner, registered nurse, or someone else? How many years of medical experience should they have?

Only registered medical practitioners possessing the necessary expertise and training with 5 years experience.

Question 21: What topics should be covered in the mandatory training for VAD practitioners?

- Elder Abuse and how to identify it, protect against it and ensure a patient is not being coerced.
- Cultural training on death, dying & blame.
- Cultural training on the sanctity of life.
- Decision-making capacity.
- Palliative care options.
- Reporting misuse.
- Reporting people's refusal to use the health care system due to their concerns regarding the presence of assisted suicide (covered in detail under Question 8).
- Conscientious objector rights.

Question 22: What process should be in place to ensure that an eligible person's access to VAD is safe and effective? How many stages should the assessment phase include? Should there be a requirement to seek specialist expertise during assessment?

**Mandatory Mental Health Assessment for Assisted Suicide Request:**

The eligibility criteria must ensure individuals undergo a mental health assessment by a psychiatrist within the month before making a first request. This assessment ensures that the person is not suffering from any undiagnosed mental illness or distress that may affect their ability to request voluntary assisted dying.

**Comprehensive Palliative Care as a Prerequisite for Assisted Suicide Eligibility:**

Eligibility criteria should ensure that individuals are ineligible for access Assisted Suicide unless they have been informed about palliative care and diagnosed with only weeks to live.

**Multi-Stage Assessment Process for Accessing Assisted Suicide:**

Each individual seeking access to Assisted Suicide must undergo a multi-stage assessment process involving evaluation by different clinicians. This process ensures thorough consideration of the individual's physical and mental health status and their capacity to make informed decisions regarding end-of-life care options. The person's treating doctors must be involved in this process. Coordinating practitioners should have at least five years specialist registration and an existing doctor-patient relationship while consulting practitioners should have similar expertise in the patient's medical condition.

Specific protections to ensure that elder abuse or coercion is not occurring, a system to report it if it is, to ensure that the patient is not just moved to another doctor.

To access Assisted Suicide the patient should be assessed by a specialist geriatrician or other relevant specialist as a minimum.

Question 23: Should one request for VAD be required in writing? How should flexibility be built in for people who cannot physically write a formal request?

**Prohibition of Verbal or Gestural Requests:**

Legislation should prohibit individuals from requesting access to Assisted Suicide verbally, by gestures, or by other means of communication. The inclusion of gestures as a form of communication for requesting Assisted Suicide is problematic as it may lead to misinterpretation and raises questions about the individual's true intentions. This is particularly relevant to the NT and aboriginal people.

Question 24: Should witnesses be required for a person's formal requests for voluntary assisted dying? If so, who should be permitted to be a witness?

Yes, there should be witnesses. There should also be a legislative protection that any witness is not a beneficiary of the person's death.

Question 25: Should interpreters be required to sign and certify a written request where they are involved?

Yes. Also, there should be a requirement that all interpreted information provided verbally to a patient in relation to an Assisted Suicide is recorded and kept for a minimum of five years. Regular quality checks should also be undertaken, given the seriousness of the Assisted Suicide context and the importance of the patient receiving all relevant information for making an informed decision, and that the information provided is accurate.

Question 26: Should there be a set time that must lapse between the first and second request? What should this timeframe be?

Access requests must be submitted online by medical staff to ensure access dates are verifiable and compliant. In other states in Australia there have been unverified accounts of doctors backdating paperwork to give patients quicker access, which is an offence under the respective state Acts. It is difficult to prove such cases. If a doctor had to submit the initial request on an online portal, the date could be verified without a doubt. The date that the access paperwork was submitted would be "the date of first request".

Legislation must incorporate a mandatory cooling-off period of 7 days before a person can self-administer or have administered an Assisted Suicide substance. This period allows individuals to reflect on their decisions and ensures they are made voluntarily without external pressure.

Question 28: Should health practitioners be free to initiate a discussion about VAD, providing information alongside other treatment and management options such as palliative care? What other treatment options should be required to be discussed? For example, psychological support.

**ACL opposes allowing health practitioners to initiate discussions about Assisted Suicide.** We oppose recommendation 12 from the Voluntary Assisted Dying Final Report 2024 which states:

*RECOMMENDATION 12*

*Medical practitioners should be allowed to introduce the subject of VAD services to patients during discussion about treatment options.*

Assisted Suicide has been discussed at length across all public forums for years now, and those who may wish to access it, are not naïve to its availability. Discussing matters of life and death should be undertaken with the utmost sensitivity, and to initiate a discussion on Assisted Suicide when a patient is at their most vulnerable point, is inappropriate as even broaching the subject could unintentionally exasperate the patient's feelings of being a burden, or tempt them to end life early, simply because the subject was raised.

Further to this, the risk of coercion is far greater when health practitioners initiate discussions. To not allow health practitioners to initiate discussions helps mitigate coercion, either intentional or unintentional. People accessing Assisted Suicide should be of sound enough mind to specifically request access. Any initiation by health practitioners can be perceived as marketing the scheme to increase uptake. This decision should be well considered by the individual to a point of self-advocacy so that we can be mostly assured that there is no coercion involved. The argument put forward to allow access to Assisted Suicide relies heavily upon people's earnest desire to access it. If health practitioners begin initiating discussions for all eligible people, there will be an increase in uptake predominately from people that hadn't previously considered accessing it. This scheme must remain at request, as an alternative to standard healthcare, rather than making it a legitimate option in weighing up healthcare decisions. This will help it remain distinct from healthcare.

**There is often an imbalance of authority over decisions between health practitioners and patients**. Coercion can often be rejected as an impossibility, but when there is an imbalance of authority it will almost certainly happen. **Also, elderly people can be easily manipulated**. Elderly people can often have the tendency to neglect their own needs and desires for others so that they won't become a burden to the people around them. We must encourage a society that values elderly people and ensures that they know that their lives are valued despite their loss of ability and increased dependence on the people around them. Health practitioners offering the option of Assisted Suicide to elderly people would send an implied message that their lives and contribution to society won't be missed. Despite any attempt to safeguard against this, the underlying message will be a lack of value placed on their life. If we really valued a person's life above anything else, the conversation would never arise.

**Assisted Suicide Acts in other jurisdictions still contain provisions which largely prevent health practitioners from initiating discussions about Assisted Suicide.** For example, the South Australian Voluntary Assisted Dying Act 2021 prevents health care workers from initiating a discussion about Assisted Suicide. Drawing from the South Australian legal framework, explicit provisions ensuring SA must not be initiated by registered health practitioner should exist. The Northern Territory government should implement the provisions outlined in *Section 12—Voluntary assisted dying must not be initiated by registered health practitioner* of the *South Australian Voluntary Assisted Dying Act 2021.*

***12—Voluntary assisted dying must not be initiated by registered health practitioner***

*1. A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person—*
*(a) initiate discussion with that person that is in substance about voluntary assisted dying; or*
*(b) in substance, suggest voluntary assisted dying to that person.*
*(2) Nothing in subsection (1) prevents a registered health practitioner providing information about voluntary assisted dying to a person at that person's request.*
*(3) A contravention of subsection (1) is to be regarded as unprofessional conduct within the meaning and for the purposes of the Health Practitioner Regulation National Law.*

Question 29: If a health practitioner declines to be involved in a person's request for VAD, should they be required to take any particular action/s? If so, what action/s? For example, passing on information to a centralised VAD service.

**No, ACL opposes requiring health practitioners who conscientiously object to Assisted Suicide to**

**provide minimum information or a referral to an Assisted Suicide service provider**. Residential Facilities and other relevant organisations should also be allowed to conscientiously object and should not be forced to allow residents to access Assisted Suicide on site.

**Any legislation that requires health practitioners who conscientiously object to Assisted Suicide to provide minimum information will directly attack many health practitioners' freedom of conscience and any religious beliefs they may hold. Conscientious objector rights must include not providing information on Assisted Suicide. This is the case in Victoria, South Australia, Queensland and New South Wales[28].** It is consistent with other jurisdictions in Australia that NT should also protect registered health practitioners right to not provide information about Assisted Suicide.
If any NT Assisted Suicide legislation does not provide complete protection for conscientious objectors, those registered health practitioners who disagree with Assisted Suicide will have to either:

1. Act in a way that is contrary to their beliefs, which can be deeply distressing and damaging to the individual.
2. Act in a way that contravenes the *Act,* which could lead to loss of employment, financial penalties and/or imprisonment.
3. Resign as a health practitioner or move into another area of practice. This could further exacerbate access to and shortages of health practitioners.

- **The above options do not conform to Article 18 of the *International Covenant on Civil and Political Rights*[29]** which Australia is a signatory to:
    1. *Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.*
    2. *No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.*
    3. *Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.*
    4. *The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to ensure the religious and moral education of their children in conformity with their own convictions.*

    The allowance for limitations regarding protecting public health does not apply to Assisted Suicide, as it is an alternative path to healthcare, not a valid option in protecting public health.

**It is for these reasons that we oppose recommendation 12 in the 2024 report.**

Question 30: What categories of persons or professions should be permitted to conscientiously object to being involved in VAD? Should this be limited to registered health practitioners?
The NT should adopt the South Australian Voluntary Assisted Dying legal framework around conscientious objection rights. The NT should also provide conscientious objection rights to Speech Pathologists and Chaplains to not participate in any part of the Assisted Suicide process. This needs

[28] See page 20 of the NT Voluntary Assisted Dying Final Report 2024

[29] https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights

clarity as they don't fall under registered health practitioners yet can be called to be part of the VAD process. Speech Pathology Australia highlights this in detail in their submission[30].

Chaplains provide an important role in end-of-life care in hospitals and medical settings. Part of a Chaplains role is to support the spiritual needs of people in end-of-life stages. It is plausible that a patient may ask for the chaplain to be in the room during the administration of an Assisted Suicide substance. This may contradict the chaplains' personal beliefs and cause them much distress. Giving chaplains the legal protection to not be part of the Assisted Suicide process is paramount. The Australian Christian Lobby has been contacted by chaplains distressed by the roll out of Assisted Suicide in their workplaces. This protection might not exist in other jurisdictions yet, but the NT has the opportunity to be more proactive in protecting chaplains.

Question 31: Should health practitioners who conscientiously object or who choose to not participate in the VAD process be required to declare their objection or non-participation to a person who is, or may be, interested in accessing VAD? If so, when?
Yes, the NT should adopt the South Australian Voluntary Assisted Dying legal framework around conscientious objection rights.

Question 32: Should a health service be permitted to not facilitate VAD at its facilities, for example at a residential aged care facility, a hospital, or accommodation for adults with a disability?
Yes, the NT should adopt the conscientious protection provisions and rights for organisations based on the South Australian Voluntary Assisted Dying legal framework. (Please refer to Appendix A). It is very important that organisational conscientious objection rights are provided for in the NT. This gives faith-based institutions the choice to not participate in any stage of the Assisted Suicide process. This includes faith-based residential aged care, hospitals, private practice or accommodation. This can be easily implemented, as it is in South Australia. Usually, the facility will have publicly available policies specifying this as a condition of the use of the facility and organisation. This provides full transparency for those wishing to use or access their facilities and services.

**We oppose Recommendation 4 of the 2024 Report which recommended to require that residential facilities must not hinder permanent residents from accessing VAD on site.**

Question 33: Should a person have a choice between self-administration and administration by an administering health professional of a VAD substance?
Yes.

Question 34: Should one method of administration be prescribed as the default option, or should methods differ depending on the circumstances? Does this need to be prescribed in legislation, or is it a matter best determined between the registered medical practitioner and patient?
All Assisted Suicide requirements should be prescribed in legislation.

Question 36: Should administration of the VAD substance to an eligible person be witnessed by another person? If so, who should be permitted to be a witness?
Yes, there should always be a witness, and the witness should not be anyone who benefits from the eligible person's death.

[30] See Submission 182 of this inquiry https://parliament.nt.gov.au/__data/assets/pdf_file/0008/1553687/Submission-No.-182-Speech-Pathology-Australia.pdf

Question 39: What safeguards should be put in place to ensure the supply of a VAD substance by a pharmacist is safe and accessible?

There needs to be very stringent requirements and protections regarding storage of substances wherever they are held to ensure that no one accesses and consumes the substance.

Question 40: What safeguards should be put in place to ensure the safe storage of a VAD substance? Should the decision to use safe boxes or something similar be a policy decision or a decision that requires legislation?

There needs to be very stringent requirements and protections regarding storage of substances wherever they are held to ensure that no one else accesses and consumes the substance, as has already occurred in another state. There needs to be strict criminal provisions in this regard.

Question 41: Should storage requirements be different in remote communities, regional centres and/or urban communities?

There needs to be very stringent requirements and protections regarding storage of substances wherever they are held to ensure that no one else accesses and consumes the substance, as has already occurred in another state. There needs to be strict criminal provisions in this regard.

Question 42: What safeguards are necessary to determine whether or not a person has taken the VAD substance, and to ensure return of any VAD substance that has not been taken?

There needs to be very stringent requirements and protections regarding usage of Assisted Suicide substances to ensure that a death is not due to other factors and to ensure that no one else accesses and consumes the substance, as has already occurred in another state, nor that any remaining amounts are sold, stolen or given to other parties. There needs to be strict criminal provisions in this regard.

Question 43: Should health professionals be required to provide information on palliative care options if a person requests VAD?

Yes. This should be legislated. A patient should be provided with information on all standard healthcare options before access is granted to Assisted Suicide.

Question 44: Should more resources be provided for community education on palliative care?

Yes.

Question 45: How can it be ensured that VAD services are complementary to, and not at the expense of, palliative care services?

Any financial investment into starting Assisted Suicide in the NT should be matched with an increase in palliative care funding. For example, if it will cost $10 million dollars in the first financial year to start up and provide Assisted Suicide services, an additional $10 million dollars in new funding should also be provided exclusively to palliative care (not Assisted Suicide). If there is new money available for Assisted Suicide, then more money should be made available for palliative care. We don't want a scenario where Assisted Suicide is well funded and easily accessible and palliative care is not. This will also help to ensure the public that palliative care won't suffer under the roll out of Assisted Suicide.

Question 46: Must information on palliative care be delivered by a practitioner with specialised qualifications in the field?

Yes.

Question 47: Is notification to the Review Board of all deaths due to use of the VAD substance or due to another cause if that person has requested VAD appropriate and useful? Should the Coroner only be notified in particular circumstances? If so, which circumstances?
All deaths should be reported to the Review Board and the Coroner.

Question 48: What should be recorded as the cause and manner of death for a person who has died by accessing VAD?
**ACL opposes recommendation 18 of the 2024 Report**, which recommended specifying that "the Cause of death of a person who has died by VAD shall be the underlying disease or illness that would have led to the person's death without VAD".

The cause of death should be recorded as Assisted Suicide, while listing the underlying terminal illness as secondary. It is the truthful and accurate answer**.** This will ensure records and data collection are accurate and won't impact the usefulness of statistics. A requirement to lie should not be embedded in any NT legislation.

Question 49: What qualifications, including cultural and language-specific training, should be required for interpreters involved in the VAD process in the NT?
Because of the nature of Assisted Suicide, it is vitally important that any translation is accurate and comprehensive. NAATI Certification should be Mandatory.

- In Australia, NAATI (National Accreditation Authority for Translators and Interpreters) is the authoritative body that sets professional standards for translators and interpreters, including those serving courts.
- Interpreters should be required to hold at minimum a "Professional Interpreter" credential—formerly known as Level 3 accreditation from NAATI. (which is what is required to be a court translator)

Question 50: What safeguards are needed to ensure interpreters can participate in VAD in a culturally safe way?
They should be required to be qualified as above. There should be a specific script that they must fully read out to the patient. There should be a certification process requiring them to certify that they have fully provided all relevant information to the patient to enable them to make a fully informed decision. All interviews at every stage of the Assisted Suicide process that require a translator should be recorded and the recording kept. There should be quality control conducted using recorded translations.

## Consultation Topic 5: Oversight and Review

Question 51: What requirements should be set for membership of a VAD Review Board in the NT?

- Must have a member who opposes Assisted Suicide due to religious beliefs to ensure genuine scrutiny and represent the faith community.
- Must have a member who opposes Assisted Suicide due to aboriginal cultural reasons to ensure genuine scrutiny and represents the aboriginal community.

Question 52: What functions should the NT VAD Review Board fulfill?

**Scrutinising and transparency on Assisted Suicide**.

Ensuring comprehensive data is collected and shared proactively with the public annually, including:

- Misuse.
- Type of conditions suffered by patient resulting in their decision to use assisted suicide.
- Certified life expectancy at time of death from registered medical practitioner.
- Compliance with timeframes.
- Age at death.
- How many applications.
- How many applications were refused.
- Complications.
- Exact costs.
- How many staff utilised.
- Refusals to access healthcare because of concerns of being forced into Assisted Suicide.
- If a patient presents to a health practitioner for any medical reason and both of the following are met:
    1. The patient refuses to follow through with any of the following: the consult, examination, medication, further consultations or healthcare; and
    2. The health practitioner reasonably suspects that it is due to the existence of Assisted Suicide services.

Then the health practitioner should be legally required to report to the VAD Review Board. This should include the following information:

- What treatment was refused.
- The diagnosis/health condition or suspected diagnosis of the patient.
- What the potential negative impact this may have on the patient for refusing further healthcare.
- Why the health practitioner reasonably suspects refusal is due to the existence of Assisted Suicide services.
- Date of refusal.

The Board should also create safeguards against coercion or abuse, particularly in light of elder abuse. The Board should ensure all policies are publicly disclosed and accessible.

Question 57: Will reviewing the VAD legislation on its third anniversary and then every 5 years provide sufficient oversight of the operation of the legislation?

Yes, the reviews should be focused on compliance with the Act and unintended consequences only, not a process to advocate for expanded and progressive access as seen in Victoria recently.

Question 59: Is 18 months an appropriate timeframe for the implementation of a VAD Act in the NT?

We recommend no less than 18 months.

## Consultation Topic 6: Other issues

Question 60: Are there any other issues that you think should be considered?

**Recommendation 11 of the Voluntary Assisted Dying Final Report 2024.**

Recommendation 11 was: *"To access VAD in the NT, a person must have decision-making capacity at all stages. VAD should not be available for persons solely diagnosed with a mental illness."*

We agree with this recommendation, although note that under Section 4.4 of the NT Voluntary Assisted Dying Final Report 2024. it states:

*"The Panel received submissions from the NT Public Guardian and Public Trustee suggesting that specific criteria be developed for assessing the decision-making capacity of people under guardianship or with an intellectual disability.*

*The Panel broadly supports the development of specific criteria in the case of people with impaired decision making."*

We urge the Committee not to develop specific criteria in the case of people with impaired or no decision-making capacity. All people who access Assisted Suicide must have decision-making capacity at all stages.

**Explicitly exclude a person with any of the following criteria as ineligible for access to Assisted Suicide.**

- Person suffering solely from mental health issues.
- Person suffering from dementia.
    - Dementia was not recommended in the NT Voluntary Assisted Dying Final Report 2024 although it was heavily discussed. Please do not grant people suffering with dementia access to Assisted Suicide.
- Person lacking decision-making capacity (including those under public guardianship).
- Person suffering from a disability.
- Those under the age of 18.

# Appendix A – Sections of South Australian Voluntary Assisted Dying Act 2021.

**10—Conscientious objection of registered health practitioners**

A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following:

(a) to provide information about voluntary assisted dying;

(b) to participate in the request and assessment process;

(c) to apply for a voluntary assisted dying permit;

(d) to supply, prescribe or administer a voluntary assisted dying substance;

(e) to be present at the time of administration of a voluntary assisted dying substance;

(f) to dispense a prescription for a voluntary assisted dying substance.

**11—Conscientious objection of operators of certain health service establishments**

1. A relevant service provider has the right to refuse to authorise or permit the carrying out, at a health service establishment operated by the relevant service provider, of any part of the voluntary assisted dying process in relation to any patient at the establishment (including any request or assessment process under this Act).

2. A relevant service provider may include in the terms and conditions of acceptance of any patient into the health service establishment an acknowledgment by the patient that the patient—

(a) understands and accepts that the relevant service provider will not permit the establishment to be used for the purposes of, or incidental to, voluntary assisted dying; and

(b) agrees, as a condition of entry, that they will not seek or demand access to voluntary assisted dying at the establishment.

3. Subsection (4) applies in relation to a patient at a health service establishment if the patient advises a person employed or engaged by the relevant service provider at that health service establishment that they wish to access voluntary assisted dying.

4. If this subsection applies in relation to a patient at a health service establishment, the relevant service provider who operates the establishment must ensure that—

a. the patient is advised of the relevant service provider's refusal to authorise or permit the carrying out at the health service establishment of any part of the voluntary assisted dying process; and

b. arrangements are in place whereby the patient may be transferred to another health service establishment or prescribed health facility at which, in the opinion of the relevant service provider, a registered health practitioner who does not have a conscientious objection to voluntary assisted dying is likely to be able to participate in a voluntary assisted dying process in relation to the patient; and

c. reasonable steps are taken to facilitate the transfer referred to in paragraph (b) if requested by the patient.

5. To avoid doubt, this section does not apply to, or in relation to, a patient accepted into a health service establishment before the commencement of this section.

6. (6) In this section—

**health service establishment means**—

(a) a private hospital within the meaning of the Health Care Act 2008 or other private health facility of a kind prescribed by the regulations; or

(b) the whole or part of any other private institution, facility, building or place that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative, or other health services (including, to avoid doubt, places of short-term respite care); or

d. any other health service establishment of a kind prescribed by the regulations, but does not include prescribed residential premises, or any establishment declared by the regulations not to be included in the ambit of this definition;

**prescribed residential premises means**—
(a) a facility (within the meaning of Part 2);
(b) any other residential premises of a kind prescribed by the regulations; **relevant service provider** means a person or body that operates a health service establishment.

**PART 2--Conscientious objection of operators of certain residential facilities**

**15—Interpretation**
In this Part—
**deciding practitioner**, for a decision about the transfer of a person, means—

a. the coordinating medical practitioner for the person; or
b. if the coordinating medical practitioner for the person is not available, another medical practitioner nominated by the person;

**facility** means—

a. a nursing home, hostel or other facility at which accommodation, nursing or personal care is provided to persons on a residential basis who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care; or
b. a residential aged care facility; or

(c) a retirement village (within the meaning of the Retirement Villages Act 2016 );

**relevant entity** means an entity, other than a natural person, that provides a relevant service;

**relevant service** means a residential aged care service or a personal care service, or services provided in the course of administering a retirement village scheme *(within the meaning of the Retirement Villages Act 2016);*

**residential aged care** means personal care or nursing care (or both) that is provided to a person in a residential facility in which the person is also provided with accommodation that includes—

a. staffing to meet the nursing and personal care needs of the person; and
b. meals and cleaning services; and
c. (c) furnishings, furniture and equipment for the provision of that care and accommodation; "residential aged care facility" means a facility at which residential aged care is provided, whether or not the care is provided by an entity that is an approved provider under the *Aged Care Quality and Safety Commission Act 2018 of the Commonwealth;*

**residential facility** does not include—
(a) a private home; or
(b) a hospital or psychiatric facility; or

(c) a facility that primarily provides care to people who are not frail and aged.

**16—Meaning of permanent residents of certain facilities**

1. A person is a **permanent resident** at a facility if the facility is the person's settled and usual place of abode where the person regularly or customarily lives.
2. A person is a **permanent resident** at a facility that is a residential aged care facility if the person has security of tenure at the facility under the Aged Care Act 1997 of the Commonwealth or on some other basis.
3. A person is not a permanent resident at a facility if the person resides at the facility temporarily.

**17—Access to information about voluntary assisted dying**

(1) This section applies if—
(a)
(b) a person is receiving relevant services from a relevant entity at a facility; and the person asks the entity for information about voluntary assisted dying; and
(c) provided, the information that has been requested.
the entity does not provide at the facility, to persons to whom relevant services are

(2) The relevant entity and any other entity that owns or occupies the facility—
(a) must not hinder the person's access at the facility to information about voluntary assisted dying; and
(b) must, on request, allow reasonable access to the person at the facility by a registered health practitioner or other person to enable the registered health practitioner or other person to personally provide the requested information about voluntary assisted dying to the

**25—Relevant entities to inform public of non-availability of voluntary assisted dying at facility**

1. This section applies to a relevant entity that does not provide, at a facility at which the entity provides relevant services, services associated with voluntary assisted dying (including, without limiting this subsection, access to the request and assessment process or access to the administration of a voluntary assisted dying substance).
2. The relevant entity must publish information about the fact the entity does not provide any services, or services of a specified kind, associated with voluntary assisted dying at the facility.
3. The relevant entity must publish the information in a way in which it is likely that persons who receive the services of the entity at the facility or may in future receive the services of the entity at the facility, become aware of the information.

Drawing from the South Australian legal framework, explicit provisions ensuring SA must not be initiated by registered health practitioner should exist. The Northern Territory government should implement the provisions outlined in *Section 12—Voluntary assisted dying must not be initiated by registered health practitioner* of the *South Australian Voluntary Assisted Dying Act 2021.*

**12—Voluntary assisted dying must not be initiated by registered health practitioner**

1. A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person—

(a) initiate discussion with that person that is in substance about
voluntary assisted dying; or

(b) in substance, suggest voluntary assisted dying to that person.
(2) Nothing in subsection (1) prevents a registered health practitioner providing information about voluntary assisted dying to a person at that person's request.
(3) A contravention of subsection (1) is to be regarded as unprofessional conduct within the meaning and for the purposes of the Health Practitioner Regulation National Law.