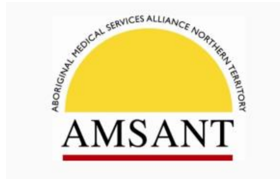
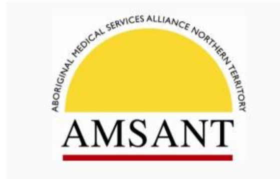


AMSANT Submission: Voluntary Assisted Dying Inquiry

Aboriginal Medical Services Alliance NT (AMSANT) is the peak body for Aboriginal Community-Controlled Health Services (ACCHS) in the Northern Territory (NT). Our sector is the largest provider of Comprehensive Primary Health Care (CPHC) to Aboriginal people in the NT and has been a primary driver of many health gains for Aboriginal people over the last five decades. AMSANT represents 12 full-member organisations and 14 associate members across the Territory, from regional centres to the most remote communities.

ACCHSs deliver a range of services as part of a broad model of CPHC that is reflective of a holistic understanding of health adopted by Aboriginal people. ACCHS deliver a wide range of clinical and non-clinical services including general practice, allied health, social and emotional wellbeing, psychosocial support, family support, youth support, early childhood development, education and care, health promotion, public health, aged care, and disability services.

AMSANT aims to grow a strong Aboriginal community controlled primary health care sector by supporting our members to deliver culturally safe, high quality comprehensive primary health care that supports action on the social determinants of health; and represent our members' views and aspirations through advocacy, policy, planning, and research. Communities taking control of their own health and human services brings benefits in many forms - a more responsive health and human services system, improved quality and cultural security of services and improved heath of and wellbeing of families and communities.

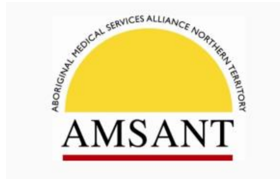


There are diverse views amongst Aboriginal people on Voluntary Assisted Dying (VAD) and, as such, AMSANT will defer to the views of our Members and Aboriginal people regarding support or dissent for VAD as an option. AMSANT does take the position, however, that if VAD is to proceed as an option for people in the NT, certain conditions must be met:

1. **Significantly increased resourcing for and the design of appropriate models for quality palliative care:** If people are to be in a position to make truly free and voluntary decisions about whether they will be assisted to die, they must have available to them quality of life services such as a responsive palliative care provision inclusive of family and social supports. In the NT, particularly in remote communities, but also in urban areas and smaller towns, access to quality palliative care and appropriate in-home support is limited or non existent. On this basis, any legislation enabling VAD must address the need for alternative and appropriate pathways to be in place that truly enables meaningful choices as opposed to 'die in extreme pain with family', 'die in less pain without family' or 'just die quickly'.

2. **Meaningful and robust engagement with Aboriginal people:** The NT was the first jurisdiction in the world to introduce VAD in 1995. (The law was only in effect for four months until the Federal Government overruled it). The legislation was contentious, after it was enacted into law, the NT Government initiated a consultation process with Aboriginal people - a flawed process, given that consultation should have occurred prior to any decision about implementation. However, the consultation process was thorough, and many meetings were held in regional and remote community settings. This work's findings described widespread concerns and opposition held by Aboriginal people to VAD. These forums heard that Aboriginal people were fearful, for themselves and their families, of seeking health care for fear of "being euthanised" without their consent. Aboriginal people also opposed VAD on moral and cultural grounds – the majority viewing it as being abhorrent.

   In 2023/24, the current consultation process being undertaken by the Northern Territory Government's VAD Panel also appears not to have included the many voices of the NT's remote Aboriginal communities. As a result, individual Aboriginal people, ACCHS and ACCOs have been placed in a situation where, knowing the concerns previously held by their constituents had not likely changed, and not being included in the formative stages of this initiative, they have had to self-organise to participate with their own limited resources. AMSANT would like to highlight this excerpt from the Productivity Commission's recent Review of the Closing the Gap Agreement:



The Agreement… notes that funding should allow Aboriginal and Torres Strait Islander parties to… engage independent policy advice, meet independently of governments and engage with affected communities… Despite this commitment… lack of time and resourcing… imped[e] their ability to participate in partnerships. Combined with insufficient timeframes for engagement, the risk of inadequate funding is that partnership processes may be viewed as disingenuous by Aboriginal and Torres Strait Islander groups and communities and reduce their capacity and willingness to participate (pp. 47-48).

On this basis, if the next stage of VAD investigation/legislative development is to proceed, substantial resourcing will be required to consult and engage appropriately with Aboriginal people across the NT. This should be co-designed with Aboriginal Peak Organisations Northern Territory (APO NT) and should be resourced properly to enable an authentic co-design and engagement process.

3. **A social/cultural approach to the design and governance of VAD:** AMSANT notes the Committee's question about establishing a Panel of Practitioners to oversee VAD. Clinical oversight is obviously essential. However, VAD is not exclusively a medical issue and to limit governance arrangements to include clinicians alone ignores the deep cultural and social significance of the issues associated with the process of dying, death and grieving. Medically managing the process of dying and death is only one consideration and AMSANT supports a process that fully considers the range of cultural, social and emotional wellbeing factors associated with VAD, and the design and establishment of holistic governance mechanisms to address these in culturally safe and appropriate ways.

4. **Choice for services and clinicians:** any legislation enabling VAD in the NT should not mandate primary health care services and individual clinicians to participate in VAD. Services and individual clinicians should be given the option not to participate. This is already in place in other jurisdictions.