



ACT Voluntary Assisted Dying Clinical Guidelines

August 2025

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- NSW Voluntary Assisted Dying Clinical Practice Handbook version 2.0, from Ministry of Health.
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ACT Health and Community Services Directorate acknowledges the Ngunnawal people as traditional custodians of the land and recognise any other people or families with connection to the lands of the ACT and region. ACT Health and Community Services Directorate wishes to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

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Section 1:

An overview of voluntary assisted dying in the ACT

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1. Introduction

Voluntary assisted dying is an end of life option which can be lawfully accessed by eligible people in the ACT from 3 November 2025.

This process gives eligible people the option to end their life by the administration of an approved substance at a time of their choosing. A person requesting access to voluntary assisted dying must meet all the eligibility requirements and follow every step in the process within the ACT.

Voluntary assisted dying, alongside high quality healthcare and palliative care, is an end of life choice designed to support people to live comfortably and die with dignity.

1.1 Overview of the voluntary assisted dying process

Figure 1: Voluntary assisted dying process in the ACT



Health practitioners who are authorised to provide voluntary assisted dying services are required to notify the Voluntary Assisted Dying Oversight Board (the Board) at key steps throughout the process. Completing and submitting the approved forms on the online portal automatically notifies the Board at each step of the process. This gives the Board oversight over the person's continuum of care throughout the voluntary assisted dying process.

1.2 Principles of voluntary assisted dying in the ACT

Voluntary assisted dying aims to support a person's autonomy to make decisions to reduce their suffering and exercise choice about the time and manner of their death.

There are safeguards built into the voluntary assisted dying process to uphold high-quality, person-centred care and to protect all members of the community from coercion and exploitation.



Principles underpinning voluntary assisted dying in the ACT

- every human life is of fundamental importance
- every person has inherent dignity and should be treated with compassion and respect
- a person's autonomy, including their end of life choices, should be respected
- every person approaching the end of their life should be provided with high quality, person-centred care and treatment, including palliative care, to minimise their suffering and maximise their quality of life
- every person has the right to be supported in making informed decisions about treatment and end of life choices
- all people should be protected from coercion and exploitation, and
- all people, including health professionals, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

2. Purpose of this document

The *ACT Voluntary Assisted Dying Clinical Guidelines* (**the Guidelines**) describe the voluntary assisted dying process in the ACT and supports health professionals to adhere to the *Voluntary Assisted Dying Act 2024*.

The purpose of the Guidelines is to support health professionals to understand:

- the request and assessment process to access voluntary assisted dying in the ACT
- their roles and responsibilities under the *Voluntary Assisted Dying Act 2024*, and
- functions of the Voluntary Assisted Dying Care Navigator Service, the Voluntary Assisted Dying Pharmacy Service, and the Voluntary Assisted Dying Oversight Board.

Further guidance has been included in the Guidelines to support health professionals in their understanding of:

- the intersection between palliative care and voluntary assisted dying
- how to engage in considered end of life discussions with a person accessing, or considering accessing, voluntary assisted dying, and

- voluntary assisted dying for diverse populations, including for Aboriginal and Torres Strait Islander peoples, and for people with disability, mental disorder or mental illness.

Health professionals should ensure that all discussions around voluntary assisted dying are conducted with empathy, privacy, and sensitivity to the emotional and psychological state of the person and their support network. Respect should extend to carers and families, including bereavement support options after the person's death.

The Guidelines support collaborative decision-making and promote shared understanding between health professionals and people considering voluntary assisted dying. Health professionals should approach each interaction with curiosity, openness, and a commitment to supporting the person's informed and voluntary choices.

The Guidelines may also be a useful reference for private care facilities and service providers, including private hospitals and residential aged care facilities.

The Guidelines are supported by the *ACT Voluntary Assisted Dying Prescription and Administration Manual* (**the Manual**). The Manual will be supplied to authorised voluntary assisted dying practitioners (authorised practitioners) upon successful completion of the assessment component of the mandatory training.

Information and guidance in the Guidelines is not a substitute for the *Voluntary Assisted Dying Act 2024* and *Voluntary Assisted Dying Regulations 2025*.

3. The Voluntary Assisted Dying Act 2024

The [Voluntary Assisted Dying Act 2024](#) (**the Act**) gives eligible people the lawful choice to access voluntary assisted dying in the ACT.

3.1 Eligibility criteria

Under the Act, a person must meet strict eligibility criteria to access voluntary assisted dying in the ACT.

Two authorised practitioners must independently determine that the person requesting voluntary assisted dying meets the following eligibility criteria:



Eligibility criteria to access voluntary assisted dying in the ACT

- they are an adult aged 18 years or older
- they have a diagnosed condition (relevant condition) that is advanced, progressive and expected to cause death, either on its own or in combination with other diagnosed conditions
- they are suffering intolerably because of their relevant condition/s
- they have decision making capacity in relation to voluntary assisted dying
- their decision to access voluntary assisted dying is made voluntarily and without coercion, and
- they have lived in the ACT for at least the last 12 months, or they have been granted a residency exemption by the Director-General.

More information about assessing a person's eligibility for voluntary assisted dying is described in [*Section 4: Voluntary assisted dying process*](#).

3.2 Protections and offences

The Act details safeguards to ensure that accessing voluntary assisted dying in the ACT is lawful and appropriate. When providing voluntary assisted dying services, authorised practitioners must act in accordance with relevant legislation, codes of conduct and within their scope of practice.

3.2.1 Protections from liability

People are not criminally or civilly liable for engaging in conduct honestly and on reasonable grounds under the Act.

People who are involved in the voluntary assisted dying process will not be liable for undertaking actions (or omitting to undertake an action) if they are acting honestly and without recklessness under the Act, or in the reasonable belief that they are engaging in conduct under the Act. This includes health professionals, carers, family members or friends.

If a health practitioner or member of the ambulance service believes on reasonable grounds that a person has self-administered or was administered an approved voluntary assisted dying substance in accordance with the Act, and the person has not requested life sustaining treatment, the health practitioner or ambulance service member will not be criminally or civilly liable for withholding or not providing life sustaining treatment.

In the event the person accessing voluntary assisted dying makes a request for life sustaining treatment once the approved voluntary assisted dying substance has been administered, the health practitioner or ambulance service member must provide it.

3.2.2 Protections for vulnerable people

There are safeguards in the Act to protect vulnerable members of the community from exploitation, coercion and abuse related to voluntary assisted dying, these include:

- people who request voluntary assisted dying must be found eligible against strict criteria as assessed by two independent authorised practitioners
- a comprehensive request and assessment process where a person communicates and reinforces their intention to access voluntary assisted dying
- the person's decision to access voluntary assisted dying is made voluntarily and without coercion
- criminal offences for acting as an authorised practitioner if they:
 - are a family member of the person
 - know or believe they are a beneficiary under the will of the person, or
 - know or believe they may otherwise benefit from:
 - assisting the person to access voluntary assisted dying, or
 - the person's death.
- requirements when raising voluntary assisted dying that health professionals ensure that the person is made aware of available palliative care and treatment options.

3.2.3 Offences under the *Voluntary Assisted Dying Act 2024*

A full list of offences under the Act can be found in [Section 7: Appendices and resources](#).

3.2.4 Offences under the *Commonwealth Criminal Code Act 1995*

The *Commonwealth Criminal Code Act 1995* (Criminal Code) criminalises the use of a carriage service to access, transmit or otherwise distribute 'suicide related material'. The Federal Court of Australia confirmed that the term 'suicide' as used in the Criminal Code applies to the ending of a person's life in accordance with voluntary assisted dying legislation in all Australian jurisdictions.¹

Under the Act, a person who dies by administration of an approved voluntary assisted dying substance does not die by suicide. However, the Criminal Code is a Commonwealth law which applies to all Australian jurisdictions.

¹ *Carr v Attorney-General (Cth)* FCA 1500 (30 November 2023).

A 'carriage service' means any method of communicating or transmitting information which uses the internet, the cloud, telephone, videoconferencing, fax or other online applications.

The term 'suicide related material' is used to describe the types of material that is prohibited from being shared by a carriage service.

Certain information is considered 'suicide related material' if the material directly or indirectly:

- counsels or incites suicide or attempted suicide, or
- promotes or provides instruction on a particular method of committing suicide.

If someone accesses 'suicide related material' with the intent to counsel or incite suicide, or provide instruction on a particular method of suicide, this would be a breach of the Criminal Code. Similarly, this also applies if a person shares this material with someone else who intends to counsel or incite suicide or provide instruction on a particular method of suicide.

It is recommended that the following communications related to voluntary assisted dying **do not occur** via telehealth or another carriage service:

- advice in relation to an administration decision
- discussing, prescribing or dispensing the approved voluntary assisted dying substance, including discussions in relation to the appropriate administration protocol, and
- informing a person how to prepare or administer the approved voluntary assisted dying substance, or any information regarding the expected effects of the substance and course to death.

Where there is a high risk of breaching the Criminal Code, information sheets and other resources must be issued in hard copy and provided in person.

Using telehealth or another carriage service presents a lower risk in the following settings:

- providing general information about voluntary assisted dying, including information about the Voluntary Assisted Dying Care Navigator Service
- receiving a first request for voluntary assisted dying, and
- conducting a first or consulting assessment, provided there is no attempt to discuss the substances involved.

Under the Criminal Code it is an offence to:

- use a carriage service to access, transmit or otherwise distribute 'suicide related material'. This offence attracts a maximum penalty of 1,000 penalty units.
- make false or misleading statements. This offence attracts a maximum penalty is 500 penalty units, imprisonment for 5 years or both.

4. Voluntary assisted dying support services

4.1 Voluntary Assisted Dying Care Navigator Service (VAD-CNS)

The Voluntary Assisted Dying Care Navigator Service (VAD-CNS) provides the ACT community with a point of contact in relation to voluntary assisted dying. It is located within Canberra Health Services.

The VAD-CNS is staffed by health professionals called 'care navigators'.



The role of the VAD-CNS

- provide information about voluntary assisted dying in the ACT
- provide support and information to guide eligible people through the voluntary assisted dying process
- provide support and information for people found not eligible for voluntary assisted dying
- refer people to relevant services/resources/specialists (including clinical and community-based services)
- connect people with authorised practitioners
- provide a link to the Voluntary Assisted Dying Pharmacy Service
- provide psychosocial support to the person and their support network, including after the person's death
- provide verification of death when needed
- witness voluntary assisted dying substance administration when needed
- provide culturally appropriate support
- provide information on specialist palliative care services or primary palliative care services and offer referral as required
- provide a first point of contact for all health professionals on voluntary assisted dying
- provide education about the voluntary assisted dying process to Canberra Health Services health professionals
- provide information to interested health professionals on accessing mandatory training and the registration process
- help authorised practitioners find specialists/second opinions when needed
- VAD-CNS medical lead only: undertakes voluntary assisted dying eligibility assessments when needed, and
- provide psychosocial support and connection through the voluntary assisted dying community of practice.

The VAD-CNS is open from Monday to Friday 8:30am to 5:00pm (excluding public holidays).

4.2 Voluntary Assisted Dying Pharmacy Service (VAD-PS)

The Voluntary Assisted Dying Pharmacy Service (VAD-PS) ensures eligible people can access the approved voluntary assisted dying substance, and other required medications, in accordance with best practice. The VAD-PS is co-located with the VAD-CNS to facilitate person-centred care.



The role of the VAD-PS

- provide education for people accessing voluntary assisted dying, their support network and authorised practitioners about the approved voluntary assisted dying substance, including adjunct medication, and methods of administration
- undertake procurement and safe storage of the approved voluntary assisted dying substance prior to dispensing
- obtain, authenticate and validate prescriptions
- compound, dispense, label and package the approved voluntary assisted dying substance for self-administration or practitioner administration
- undertake disposal of unused/remaining approved voluntary assisted dying substance
- maintain appropriate records, including a register of supply, possession and disposal for the approved voluntary assisted dying substance
- witness approved voluntary assisted dying substance administration when needed
- support people undertaking voluntary assisted dying and their support network in relation to self-administration of the approved voluntary assisted dying substance, including supplying the approved voluntary assisted dying substance and undertaking home visits when needed
- assess a person seeking to access voluntary assisted dying to ensure that the formulation of the approved voluntary assisted dying substance supplied is suitable for their use and provide advice about safe storage of the substance
- provide authorised practitioners with advice on protocols for prescription and administration, and
- report on key performance indicators.

The VAD-PS is open from Monday to Friday 8:30am to 4:30pm (excluding public holidays).

4.3 Voluntary Assisted Dying Oversight Board

An independent, statutory board is established under the Act to monitor compliance and report to the Minister for Health on suggested improvements and safeguards to the voluntary assisted dying process.

The Voluntary Assisted Dying Oversight Board (the Board) must ensure the safe operation of voluntary assisted dying in the ACT and refer any matters of concern to the appropriate body.



Functions of the Board

- monitor the operation of the Act
- monitor requests for voluntary assisted dying
- refer any issues to the relevant persons/bodies, including the Chief Police Officer, Coroner, the Director-General, Human Rights Commission, Ahpra, the registrar-general
- provide advice to the Minister for Health in relation to the:
 - operation of the Act
 - the functions of the Board
 - improvement of the processes and safeguards for voluntary assisted dying.
- analyse information given to the Board under the Act and research matters relating to the operation of the Act, and
- maintain record keeping and report at least annually.

Members of the Board are appointed by the Minister for Health and will include a minimum of four, but no more than seven members, including a Chair. Each of the appointed members must have knowledge and expertise in one or more relevant areas: medicine; nursing; pharmacy; psychology; social work; ethics; law; health care consumer, disability, carer representation or advocacy; or any area the Minister considers relevant to the Board's functions.

4.4 Voluntary Assisted Dying Online Portal

The Voluntary Assisted Dying Online Portal (online portal) is a secure online platform used by authorised practitioners and the Board to meet the legislative requirements throughout the voluntary assisted dying process.

The online portal automatically notifies the Board when the required forms have been submitted. This allows the Board to carry out its functions as described above.

Completing the forms in the online portal does not replace clinical documentation in the person's health record. This must occur as per standard practice.

5. Key terms

The table below provides plain English definitions for a selection of key terms relevant to voluntary assisted dying. Further and more detailed definitions for some of the below and other terms can be found in the [Voluntary Assisted Dying Act 2024](#).

Table 1: Key terms

Term	Definition
The Act	The <i>Voluntary Assisted Dying Act 2024</i> .
ACT Civil and Administrative Tribunal (ACAT)	ACT Civil and Administrative Tribunal is a key legal institution that provides a forum for resolving disputes and to review administrative decisions made by government.
Administration	The direct administration of a prescribed substance to the body of a person, by a person who is authorised to do so.
Administering practitioner	A medical practitioner, nurse practitioner or registered nurse who is authorised to administer the approved voluntary assisted dying substance to a person if the person chooses practitioner administration.
Administration decision	A person's decision to either self-administer the approved voluntary assisted dying substance, or have it administered by an administering practitioner, made in collaboration with their coordinating practitioner.
Advanced condition	A relevant condition/s is considered advanced if: a) the person's functioning and quality of life: i. have declined or are declining ii. are not expected to improve, and b) any treatments for the condition/s that are reasonably available and acceptable to the person have lost any beneficial impact, and c) the person is approaching the end of their life.
Agent	An individual who acts on behalf of the person seeking to access voluntary assisted dying.
Ahpra	Australian Health Practitioner Regulation Agency.
Approved voluntary assisted dying substance	A medicine approved under section 56 of the Act for the purpose of causing a person's death.
Approved disposer	A pharmacist employed by Canberra Health Services who is approved by the Director-General to dispose of the approved voluntary assisted dying substance/s.
Approved supplier	A pharmacist employed by Canberra Health Services who is approved by the Director-General to supply the approved voluntary assisted dying substance.

Assisting person	An adult who has been asked to prepare the approved voluntary assisted dying substance for the person to self-administer.
Authorised voluntary assisted dying practitioner (authorised practitioner)	A medical practitioner, nurse practitioner or registered nurse who meets the eligibility requirements and has successfully completed the mandatory training. Medical and nurse practitioners are authorised to perform the role of coordinating or consulting practitioner and/or administering practitioner. Registered nurses can only be authorised as administering practitioners.
Business day	Any day other than a Saturday, Sunday, or a public holiday or bank holiday in the ACT.
Carer	An individual who provides unpaid support to a family member or friend with a disability, mental illness, ongoing medical condition or age-related frailty.
Carriage service	Any electronic method of communicating, including telephone, internet, email, fax, videoconference, or other online applications. Carriage services include online systems for accessing and storing information.
Coercion	The use of force, threats or intimidation to compel a person to act in a way that is against their will.
Conscientious objection	The objection by a person or organisation to performing a role or participating in the provision of voluntary assisted dying because it would conflict with their religious or personal beliefs or values, or because of moral concerns.
Consulting assessment	The second of two assessments to determine eligibility to access voluntary assisted dying, conducted by the person's consulting practitioner.
Consulting practitioner	The authorised voluntary assisted dying practitioner responsible for undertaking the consulting assessment.
Contact person	An adult appointed by a person who has made a self-administration decision. A contact person has specific responsibilities they must fulfill to support a person accessing voluntary assisted dying.
Coordinating practitioner	The authorised voluntary assisted dying practitioner who accepts a person's first request and coordinates their voluntary assisted dying process.
Death certificate (Medical Certificate of Cause of Death)	The legal document completed by a medical practitioner certifying a person's cause of death.
Deciding practitioner	A medical practitioner responsible for deciding whether it is reasonable for a resident of a facility to be transferred to another facility for the purpose of accessing voluntary assisted dying.

Decision-making capacity	Decision-making capacity refers to the ability of a person to make an informed and reasoned choice and is defined in detail at section 12 of the Act. Generally, a person has decision making capacity in relation to voluntary assisted dying if they: • can be informed and understand the relevant facts that relate to a decision about accessing voluntary assisted dying • understand the choices available to them • can weigh up the consequences of those choices • understand how the consequences affect them, and • can make a decision considering all of the factors and communicate this decision in whichever way they are able.
Director-General	The Director-General of the ACT Health and Community Services Directorate or their delegate.
Eligible person	A person who has met all eligibility requirements to access voluntary assisted dying.
Final request	The third of three clear and unambiguous requests a person must make to access voluntary assisted dying.
Final assessment	Conducted by the coordinating practitioner after receiving the person's final request.
First assessment	Conducted by the coordinating practitioner to determine whether the person is eligible to access voluntary assisted dying.
First request	A clear and unambiguous request to access voluntary assisted dying made by a person to an authorised practitioner. This is the first of three formal requests an eligible person is required to make to access voluntary assisted dying.
Health practitioner	A person registered under the <i>Health Practitioner Regulation National Law</i> to practise a health profession, including a student. For example, a medical practitioner, nurse practitioner, registered nurse, or pharmacist. It does not include health professionals that work in self-regulated professions, such as social workers.
Health professional	Includes health practitioners and other healthcare workers in self-regulated professions such as counselling, social work, or speech pathology.
Health record	Any record, or part of a record, containing personal health information or that is held by a health service provider containing personal information.
Interpreter	An interpreter who preferably holds a credential issued under a professional body such as the National Accreditation Authority for Translators and Interpreters (NAATI). The interpreter must not:

	• be a family member or friend of the person • know or believe that they are a beneficiary under the will of the person • know or believe they may benefit financially or in any other material way from assisting the person to access voluntary assisted dying or the death of the person, other than by receiving reasonable fees for interpreting services • be an owner or responsible for the management of a facility where the person is a resident, and • be directly involved in providing a health service, aged care service or personal care service to the person.
Medical practitioner	A doctor registered under the <i>Health Practitioner Regulation National Law</i> and who has active registration with Ahpra.
Nurse practitioner	A nurse registered under the <i>Health Practitioner Regulation National Law</i> who is endorsed as a nurse practitioner and who has active registration with Ahpra.
Palliative care	Person and family-centred care for a person with an advanced, progressive and life-limiting condition, including the frail aged. Palliative care seeks to prevent and relieve suffering through the early identification, assessment and treatment of pain and other symptoms.
Practitioner administration	Administration of an approved voluntary assisted dying substance by an administering practitioner.
Private care facility	A nursing home, hostel, respite facility, group home or other facility where accommodation, nursing or personal care is provided to individuals. Care could be required because of infirmity, frailty, illness, disease, incapacity or disability.
Progressive	An individual's condition is progressive if their condition is deteriorating and will continue to deteriorate.
Registered nurse	A nurse registered under the <i>Health Practitioner Regulation National Law</i> and who has active registration with Ahpra.
Relevant condition	A medical condition or disease which has been diagnosed either on its own, or in combination with other diagnosed conditions, that is advanced, progressive, and expected to cause death.

Relevant health professional	A health professional with obligations when raising voluntary assisted dying as an end of life choice, as defined by the Regulation. Including: • social workers • counsellors • speech pathologists, and health practitioners, other than medical or nurse practitioners who knows or reasonably believes that a person has been diagnosed with an eligible condition and has the expertise to discuss treatment and palliative care options with the person.
Second request	The second of three clear and unambiguous requests a person must make to access voluntary assisted dying. It must be made in writing and signed by the person or their agent in the presence of two eligible witnesses, and include specific statements required by the Act.
Self-administer/ self-administration	Administration of an approved voluntary assisted dying substance by the eligible person.
Strict liability offence	An offence of which a person may be found guilty even if they did not intend to commit an offence, so long as the person's actions are proved to have caused the offence.
Voluntary Assisted Dying Care Navigator Service (VAD-CNS)	Provides support and information to people accessing voluntary assisted dying, their family and loved ones, health professionals and private care facilities.
Voluntary Assisted Dying Care Navigator (care navigator)	A health professional employed by the Voluntary Assisted Dying Care Navigator Service (VAD-CNS) who can provide support, assistance and information about voluntary assisted dying. Also referred to as a 'care navigator'.
Voluntary Assisted Dying Oversight Board (the Board)	Established under the Act to monitor and report on the voluntary assisted dying processes in the ACT.
Voluntary Assisted Dying Pharmacy Service (VAD-PS)	Responsible for coordinating access to the approved voluntary assisted dying substances in the ACT. Pharmacists working in the VAD-PS are approved suppliers and disposers of the approved voluntary assisted dying substances.
The Voluntary Assisted Dying Online Portal (online portal)	A secure online platform used by authorised practitioners and the Board for the submission of required documentation and oversight of the voluntary assisted dying process.
Witness to second request	An eligible witness to a person's second request for voluntary assisted dying is a person who: • is an adult • is not a beneficiary under the will

- will not benefit financially from assisting the person to access voluntary assisted dying or from the death of the person
- is not an owner or responsible for the management of a facility where the person is a resident, and
- is not the person's coordinating or consulting practitioner.

Witness to substance administration

An adult who is present during practitioner administration of the approved voluntary assisted dying substance.

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Section 2: End of life planning

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1. Voluntary assisted dying as an end-of-life choice

1.1 Palliative care

Palliative care aims to relieve suffering by the early identification, assessment and treatment of pain and other physical or psychosocial symptoms. However, palliative care cannot always effectively manage pain, symptoms or suffering in a way that is tolerable. For some people, simply having the knowledge that they can access voluntary assisted dying may alleviate or reduce their suffering to a tolerable level. Voluntary assisted dying may allow people to maintain an acceptable level of independence, dignity and choice at the end of their lives.

Palliative care should continue to be available to a person seeking access to voluntary assisted dying until the time of their death. Palliative care can be provided by many clinicians, including general practitioners. For people who have advanced conditions with complex needs, specialist palliative care services are available.

Palliative care services can be usually provided at home and in healthcare settings, more information about palliative care services in the ACT can be found online at [Palliative Care Services](#).

1.2 Advance care planning

Advance care planning is a process of planning for health care, where a person's values and preferences are documented to guide future decisions when that person can no longer make or communicate their decisions.

An advance care planning document is relied upon when a person loses their decision-making capacity. To access voluntary assisted dying, a person must maintain decision making capacity throughout the process. This means that a person **cannot make a valid request** for voluntary assisted dying **in an advance care planning document**. Similarly, an **enduring power of attorney cannot** make a request for voluntary assisted dying on a **person's behalf**.

If a person expresses interest in voluntary assisted dying during advance care planning conversations, the health professional should provide information about the:

- voluntary assisted dying eligibility criteria in the ACT
- process of making a first request, and
- Voluntary Assisted Dying Care Navigator Service (VAD-CNS).

Advance care planning should still occur even when a person wishes to access voluntary assisted dying. This ensures that other end of life preferences, such as the ability to refuse or cease life sustaining medical treatment, can be respected in cases where the person loses decision-making capacity and cannot complete the voluntary assisted dying process.

The following health professionals are typically involved in advance care planning discussions:

- specialist physicians
- acute care treating team
- general practitioners
- social workers, and
- Canberra Health Services Advance Care Planning Team.

Regardless of who initiates the advance care planning discussion, it is important that the outcome is documented in the person's health record and relayed to a person's general practitioner.

More information can be found at [Advance care planning](#).

2. Discussing voluntary assisted dying

2.1 Raising voluntary assisted dying as an end of life choice

A medical or nurse practitioner, or other 'relevant health professional' may raise voluntary assisted dying as an end of life choice, as long as they adhere to the requirements set out in the Act.

These requirements differ slightly depending on whether the person initiating the discussion is a medical or nurse practitioner or another 'relevant health professional'. Only medical or nurse practitioners and 'relevant health professionals' are subject to these requirements.

The requirements are a safeguard against the possibility that a person might feel pressured to access voluntary assisted dying in discussions with health professionals.

Medical and nurse practitioners who know or reasonably believe the person has been diagnosed with an eligible condition can raise voluntary assisted dying as an end of life option. They must have the expertise to discuss treatment and palliative care options with the person and take reasonable steps to ensure the person knows:

- a) the treatment options available for their condition/s and the likely outcome of those treatment options, and
- b) the palliative care options available to them and the likely outcome of those palliative care options.

If a medical or nurse practitioner is not satisfied that they have the expertise to appropriately discuss treatment and palliative care options with the person, they can still raise voluntary assisted dying as an end of life option, but they must follow the requirements for **'relevant health professionals'**.



Relevant health professional

A relevant health professional is a:

- a) Counsellor with qualifications that make them eligible for registration as a practising counsellor with the Australian Counselling Association Limited.
- b) Health practitioner registered by Ahpra, other than a medical or nurse practitioner.
- c) Social worker with qualifications that make them eligible for a practising membership with the Australian Association of Social Workers Limited. Excluding retired or student membership.
- d) Speech pathologist with qualifications that make them eligible for a practising membership with the Speech Pathology Association of Australia Limited.

A 'relevant health professional' may raise voluntary assisted dying as an end of life option if they know or reasonably believe the person has been diagnosed with an eligible condition. They must take reasonable steps to ensure the person knows:

- a) they have treatment and palliative care options available to them, and
- b) they should discuss these options with their treating medical team.

2.2 Having end of life discussions

Health professionals should have a person-centred approach when having end of life discussions. It's important to be responsive and adapt communication styles to align with the person's needs, preferences and health literacy. People should be asked if they would like to have their carers, family members or friends involved in end of life discussions. Plain language should be used wherever possible and use of medical terminology should be limited. Euphemisms and colloquialisms should be avoided.

Healthcare communication is rapidly being recognised as a skill that can be learned and refined. While it is acknowledged that all health professionals would benefit in communication training, discussions about end of life are often more challenging and nuanced.

Some guiding principles for healthcare communication are outlined below:

- establishing mutual respect
- developing a shared understanding of the person's goals
- fostering a supportive environment
- responding to emotion with compassion
- collaborative decision making with the person, their carers and family, and
- engaging with transparency and providing full disclosure.



Further reading on end of life conversations can be found at:
National Consensus Statement: Essential elements for safe and high quality end-of-life care.

2.3 Working with interpreters

It is important that people accessing voluntary assisted dying can clearly communicate their wishes and understand what is happening at all stages of the process. Interpreters can and should be used at any stage of the voluntary assisted dying process to facilitate communication for people who speak a language other than English or for people who use non-spoken language, such as Auslan. Health professionals must document the presence of an interpreter during a consultation.

If an interpreter is required, they must not:

- be a family member of the person
- know or believe that they are a beneficiary under the will of the person
- know or believe they may benefit financially or in any other material way from assisting the person to access voluntary assisted dying or the death of the person, other than by receiving reasonable fees for interpreting services
- be an owner or responsible for the management of a facility where the person is a resident, and
- be directly involved in providing a health service, aged care service or personal care service to the person.

If it is necessary to use an interpreter who does not meet the criteria above, an exemption may be granted if the Health and Community Services Directorate is satisfied that:

- no other interpreter is reasonably available, and
- there are exceptional circumstances for granting the exemption.

An exceptional circumstance may include where the language is only spoken by a limited number of interpreters or other reason which means that finding an interpreter who meets all requirements within a reasonable timeframe is not practical.

To ensure the appropriate skills required to provide interpreter services as part of the voluntary assisted dying processes, it is preferable that an interpreter is accredited by a professional body, such as the National Accreditation Authority for Translators and Interpreters (NAATI).

Discussions about approved voluntary assisted dying substances and administration decisions must only occur face-to-face with the person, authorised practitioner and interpreter present. This allows open communication without breaching the Criminal Code.

2.3.1 Arranging an interpreter

It is the responsibility of the authorised practitioner to arrange an interpreter if one is required.

When booking an interpreter, authorised practitioners must inform them that the consultation is related to voluntary assisted dying. This gives the interpreter the opportunity to decide if they are comfortable with the topic before accepting the assignment.

To book an interpreter:

- contact the Translating and Interpreting Service on 131 450, and
- authorised practitioners employed by Canberra Health Services can access a list of specific client codes on the Translating and Interpreting Services intranet page.

2.3.2 Translation services

Several forms need to be completed by the person after they have been found eligible to access voluntary assisted dying, including the *Second request* and *Appointment of a contact person* forms.

The *Second request* must be written in English. If the person cannot understand or write in English, an interpreter will need to sight translate it for the person. The interpreter will need to certify on the form that they have provided a true and correct translation. If the interpreter does not agree to provide sight translation, then the authorised practitioner must arrange an alternative interpreter by contacting the Translating and Interpreting Service

2.4 Working with speech pathologists

There may be times where a person requires assistance to communicate their end of life preferences. Speech pathologists can help people with declining physical function to effectively communicate using specialised aids or strategies, including:

- a communication book
- a communication display, and
- augmentative and alternative communication such as:
 - tablets
 - speech generation devices
 - gestures or facial expressions
 - amplification devices and hearing aids.

People who are being cared for in a Canberra Health Services facility can access the speech pathology service. Private speech pathology services can also be arranged through [Speech Pathology Australia](#).

3. Preparing for death

End of life planning should commence early and should include:

- appointing an enduring power of attorney and ensuring that they are aware of the person's goals of care
 - an enduring power of attorney cannot be used to authorise access to voluntary assisted dying
- completing and lodging a Will
- completing advance care planning documents
 - this cannot be used as a request for access to voluntary assisted dying
- ensuring goals of care for unexpected events (including resuscitation plans) are clearly defined and discussed with carers, family and the person's healthcare team (with consent)
- discussing timing and process of deactivation of implantable defibrillation devices (ICD)
 - liaise with the person's cardiologist/cardiology team
- considering funeral arrangements
- discussing whether the person wishes to be an organ and/or tissue donor or a body donor, and
- any wishes or requests about rituals and/or care of their body immediately after death.

3.1 Place of death

The coordinating practitioner should talk to the person about their preferred place of death. The person's preferred place of death may include the following options within the ACT:

- home
- family or friend's homes
- residential facility
- hospital
- hospice, and
- on Country.

3.2 Connections

Relationships with carers, families and friends can be more challenging when people approach the end of their life. There may be social and familial connections that the person would like to discuss or have further support put in place. Stress and worries can

often lessen if people are preparing and talking about death prior to it occurring. Some of the questions for these discussions may include:

- Has the person disclosed their decision to access voluntary assisted dying to their family and friends?
 - Is there any conflict about this decision?
- Has the person disclosed their decision to access voluntary assisted dying to their health care team?
- Are there relationships that are estranged or cause friction?
- Are there people that the person would like to say goodbye to, and have they considered doing this?
- Does the person have any concerns or fears about dying?
- Is there anything worrying the person that support services can help with?
- Does the person have responsibility for children, dependents or pets, and if so what considerations or plans will be required to put in place for them?

Health professionals should complete training in trauma-informed practice and be aware of the psychological wellbeing of the person and their carers, family and friends throughout the process. Offering mental health support proactively, not just reactively, should be a standard part of care.

Referrals to support services are available, including counselling, mental health support, social workers, pastoral and spiritual care. Referrals should occur via normal processes or by contacting the VAD-CNS.

3.3 Values and wishes

Establishing goals and wishes for a person approaching end of life will allow for person-centred care. Some prompts that may be useful for discussion about values and wishes include:

- What is important to you as a person?
- What brings you joy?
- Who are the people you want or don't want around during this time?
- Are there important cultural or religious beliefs that need to be addressed?
- Are there spiritual, cultural or religious elders you want involved in this process?
- Are there rituals or practises that should be followed at the time of your death?
- Are there pets that you would like to have visit or be around?
- Is there music that is meaningful to you, that you would like to be playing during this time?
- Do you have any favourite foods or drinks that you would like to eat or drink in the days before death?

- Are there photos, personal belongings or trinkets that you would like to have close by at or near the time of death?

Respect for religious, cultural, and spiritual end of life traditions should be proactively embedded where possible, including the involvement of cultural or spiritual leaders, rituals, and culturally significant practices.

3.4 Death and dying

People approaching the end of life will often become increasingly fatigued, spend less time out of bed, and be less interested in eating and drinking. These are all normal parts of dying.

There are several important points that should be discussed with all people preparing for death, especially in the context of voluntary assisted dying. Be mindful to ensure that any discussions remain person-centred, and family and friends are only included with the person's consent.

Points to consider include:

- Who will be present at the time of administration of the approved voluntary assisted dying substance?
 - Ensure these people are prepared for what death will look like, the signs and symptoms that may be expected, and timeframes in which death may occur.
- Who will complete the verification of death process?
 - How is that person able to be contacted and who will contact them?
- Who will complete the Medical Certificate of Cause of Death?
 - How is that person able to be contacted and who will contact them?
- If the person dies at home or in a facility without a mortuary, which funeral director will be responding?
 - Explain the process if the family wishes to keep the person's body at home for an extended period of time after death.
- Explain to the person that the Medical Certificate of Cause of Death and the formal death certificate produced by ACT Government Births, Relationships and Deaths will have different wording. The formal death certificate provided to family will not show that a voluntary assisted dying substance was administered.

3.5 Organ and tissue donation

Organ or tissue donation can be explored with people who express interest in donation following voluntary assisted dying. However, for many people seeking access to voluntary assisted dying, their relevant condition/s may preclude them from organ or tissue donation. Discussions about donation should occur only after the person has been assessed as eligible for voluntary assisted dying.

Organ donation is only possible if the person dies in a hospital following intravenous administration of the voluntary assisted dying substance.

If the person is assessed as eligible for organ donation, the coordinating practitioner must notify DonateLife ACT, the VAD-CNS and the VAD-PS. These teams will work together with the person and their coordinating practitioner to facilitate the organ donation process.

3.6 Body donation

If the person wishes to donate their body to the Australian National University (ANU) for medical training and research, the coordinating practitioner should provide details of the Body Donation Program via the [ANU website](#).

4. Grief and bereavement support

The grief and bereavement experienced by carers, families and friends following the death of a loved one from voluntary assisted dying can be unique, including the feeling of ‘anticipatory grief’. There are resources available to support people during this time.

Table 1: Grief and bereavement support in the ACT

Resources	Contact details
The VAD-CNS has dedicated social workers who are available during business hours.	Telephone: 02 5124 1888 Monday to Friday 8:30am – 5:00pm
Canberra Grief Centre provides grief counselling and support for people who have lost a friend or family member. This is a private service who charge fees for their services.	Telephone: 0409 966 515, Monday, Tuesday, Thursday, Friday 9:00am – 5:00pm www.canberragriefcentre.com.au
Solace ACT run a peer-based group that provides mutual grief and loss support after the death of a partner or spouse.	Telephone: 02 6297 1052 www.partner-loss-support-canberra.com
Griefline is a free phone service that supports anyone experiencing grief.	Telephone: 1300 845 745 Monday to Friday 8:00am – 8:00pm www.griefline.org.au

Grief Australia can help family, friends and carers deal with the death of a loved one and put them in touch with support groups.

Telephone: 1800 642 066
Monday to Friday 9:00am – 5:00pm
www.grief.org.au

Lifeline can provide crisis support to anyone who needs immediate help to deal with emotional distress.

Telephone: 13 11 14 (24 hours)
www.lifeline.org.au

ACT Government Grief and Bereavement website has resources including the brochure “When someone dies – a practical guide for family and friends”.

[Grief and bereavement - ACT Government](#)

Section 3: Information for health professionals

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1. Roles and responsibilities of authorised practitioners

1.1 Coordinating, consulting and administering practitioners

Health practitioners authorised by the Director-General ACT Health and Community Services can perform the following roles in the voluntary assisted dying process:

- coordinating practitioner
- consulting practitioner, and
- administering practitioner.

An overview of the coordinating, consulting and administering practitioner roles are described below.

Coordinating practitioner	Consulting practitioner	Administering practitioner
A medical or nurse practitioner authorised by the Director-General to be a coordinating practitioner. Coordinates all steps in the voluntary assisted dying process, including: • conducting the first assessment to determine if a person is eligible to access voluntary assisted dying • referring a person to another health practitioner for a consulting assessment • conducting the final assessment. Prescribes the approved voluntary assisted dying substance. Can perform the role of administering practitioner if they meet the requirements and are asked by the person Is the primary contact for the person in relation to accessing voluntary assisted dying. Cannot be the consulting practitioner for the same person they are the coordinating practitioner for.	A medical or nurse practitioner authorised by the Director-General to be a consulting practitioner. Conducts an independent assessment of the person's eligibility to access voluntary assisted dying. Can perform the role of administering practitioner if they meet requirements and are asked by the person. Cannot be the coordinating practitioner for the same person they are the consulting practitioner for.	A medical practitioner, nurse practitioner or registered nurse authorised by the Director-General to be an administering practitioner. Administers the approved voluntary assisted dying substance if the person chooses practitioner administration. Obtains the approved voluntary assisted dying substance from the VAD-PS and ensures safe and secure storage until it is administered to the person. Returns any unused or remaining approved voluntary assisted dying substances to the VAD-PS. Ensures a witness is present at administration of the approved voluntary assisted dying substance.

Before agreeing to act as a person's coordinating/consulting/administering practitioner, they must ensure that they **do not** have a 'personal interest' in relation to the person. A practitioner will have a personal interest in relation to a person if they:

- are a family member of the person requesting voluntary assisted dying, or
- are a beneficiary under the will of the person or
- know or believe they may otherwise benefit financially or in any other material way from assisting the person to access voluntary assisted dying or from the death of the person (other than by receiving reasonable fees for the provision of services relating to their role as an authorised practitioner).

Non-compliance with these requirements, or otherwise acting as an authorised practitioner without appropriate authority, is a criminal penalty attracting a maximum penalty of 12 months imprisonment or 100 penalty units, or both.

2. Process to become an authorised practitioner

2.1 Eligibility requirements for authorised practitioners

2.1.1 Qualification and experience requirements for coordinating and consulting practitioners

A **medical practitioner** is eligible to become authorised as a coordinating or consulting practitioner if they:

- hold specialist registration and have practised for at least one year
- hold general registration and have practised for at least five years, or
- hold specialist registration for less than one year but have practised for at least five years as the holder of general registration.

A nurse practitioner is eligible to become authorised as a coordinating or consulting practitioner if they have at least one year of experience in a relevant area of practice² post endorsement as a nurse practitioner.

The Act requires that a medical practitioner must perform either the coordinating or consulting practitioner role, if a nurse practitioner is the other authorised practitioner in the process.

² Relevant areas of practice include but are not limited to palliative care, oncology, neurodegenerative disease management, cardiology, respiratory, primary health care, aged care, intensive care, or emergency care.

2.1.2 Qualification and experience requirements for administering practitioners

Any registered **medical practitioner, or nurse practitioner** is eligible to become authorised as an administering practitioner.

A **registered nurse** is also eligible to become authorised as an administering practitioner if they have practised for at least five years as a registered nurse.

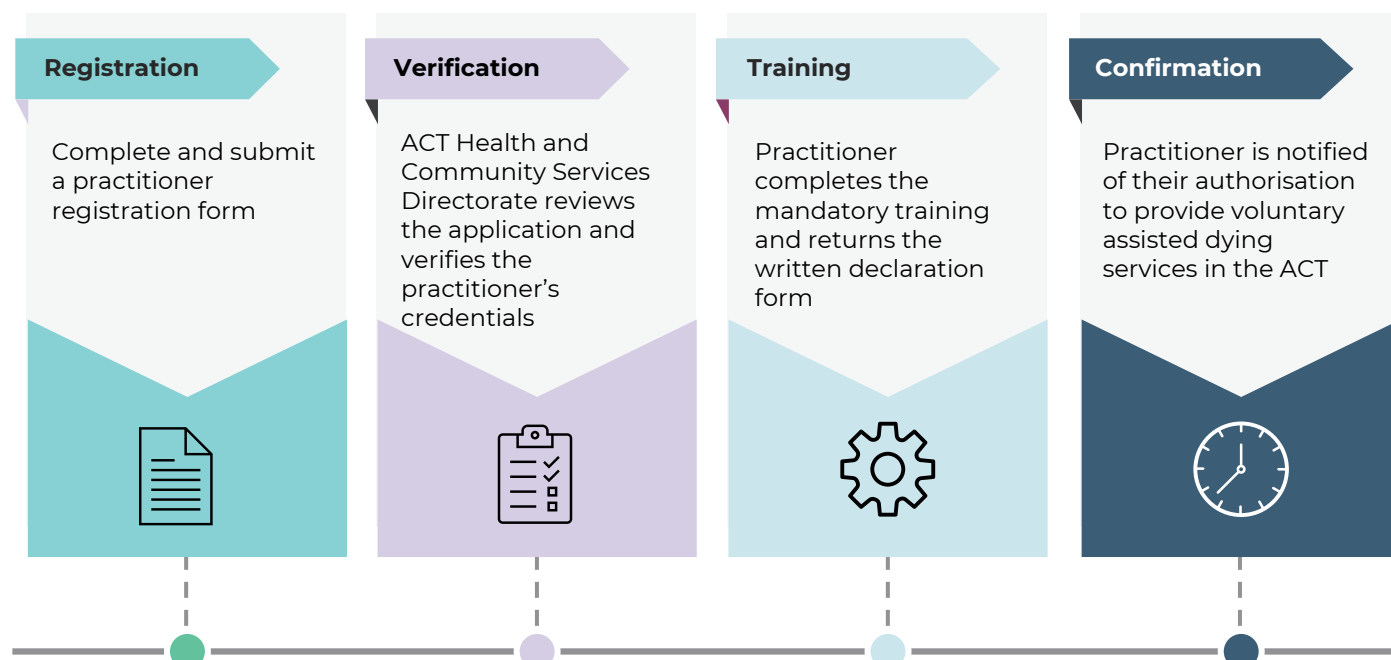
The qualification and experience requirements to be eligible to perform the role of a voluntary assisted dying authorised practitioner is summarised in Table 1.

Table 1: Eligibility to become an authorised practitioner

Type of health professional	Coordinating practitioner	Consulting practitioner	Administering practitioner
A medical practitioner who holds specialist registration and has practised for at least one year.	Yes	Yes	Yes
A medical practitioner who holds general registration and has practised for at least five years.	Yes	Yes	Yes
A medical practitioner who holds specialist registration and have practised for at least five years.	Yes	Yes	Yes
A nurse practitioner with experience in a relevant area of practice of at least one year post nurse practitioner endorsement.	Yes (if the consulting practitioner is a medical practitioner)	Yes (if the coordinating practitioner is a medical practitioner)	Yes
A medical practitioner (who does not meet the requirements above).	No	No	Yes
A nurse practitioner (who does not meet the requirements above).	No	No	Yes
A registered nurse with at least five years of experience.	No	No	Yes
A registered nurse with less than five years of experience.	No	No	No

2.2 How to apply to become an authorised practitioner

The process to become an authorised practitioner for voluntary assisted dying is outlined below:



2.2.1 Practitioner registration form and supporting documents

Health practitioners must complete and submit a practitioner registration form. The application must be accompanied by the following supporting documents:

A current curriculum vitae	Include: • years of clinical practice at the relevant registration and type, and • recent and relevant clinical practice, including experience in caring for people towards the end of life, patient assessment and clinical decision making.
Ahpra registration number and status	Disclose any conditions, investigations, adverse findings ³ , reprimands, or notations in the previous five years.
Contact details for at least two professional referees	One referee must be a practicing registered health practitioner who can verify the clinical experience of the applicant.
Certified copies of relevant qualifications	Including undergraduate degree/s, specialist qualifications, or any other relevant post graduate qualifications relevant to the application.
Certified copies of two forms of identification	This must include at least one form of photo identification.
Certified copy of proof of name change	Where the name on qualification, identification or another certified document is different.
A PDF copy of a completed and signed statutory declaration	The statutory declaration must be made via the Australian Government website.

3 (a) any health, conduct or performance action taken against the practitioner
 (b) any substantiated claims or complaints about, or adverse findings made against, the practitioner by—
 (i) a registration authority; or
 (ii) any other professional, ethical standards or disciplinary body in Australia or outside Australia
 (c) any conviction or finding of guilt for an offence in Australia or outside Australia.

2.2.2 Mandatory training

Once the health practitioner's qualifications and experience are confirmed, they will be provided access to the mandatory training. The health practitioner must complete this training before they can be authorised to provide voluntary assisted dying services.

The training requirements for coordinating, consulting and administering practitioners are the same. The mandatory training recognises and builds upon pre-existing clinical skills, providing an overview of the legal framework and core knowledge required to deliver voluntary assisted dying services in accordance with the Act.

To successfully complete the mandatory training, health practitioners must pass an assessment. If the practitioner does not successfully pass the assessment after three attempts, they will be required to complete the training again before re-attempting the assessment. The assessment is 'open book' and allows for a health practitioner to refer to these Guidelines, and any other resources during the assessment.

2.2.3 Confirmation of practitioner authorisation

Following confirmation that the health practitioner has successfully completed all training requirements, ACT Health and Community Services Directorate will notify them and confirm their authorisation as a voluntary assisted dying practitioner. The authorised practitioner will be provided with a unique identification number. With consent, the names and contact details of the authorised practitioners are provided to the VAD-CNS.

2.3 Renewal of authorised practitioner status

Practitioner authorisation for voluntary assisted dying is valid for three years from the date of notification of practitioner authorisation. Every three years, practitioners will be required to complete refresher training to maintain authorisation.

2.4 Withdrawal of services as an authorised practitioner

An authorised practitioner can withdraw their services and cease being an authorised practitioner for voluntary assisted dying at any time.

If an authorised practitioner wishes to cease providing voluntary assisted dying services, they must advise the ACT Health and Community Services Directorate in writing by emailing VADWorkforce@act.gov.au. A written notification of withdrawal will be provided, and details will be removed from the authorised practitioner register.

2.5 Mandatory disclosures to the Director-General

Authorised practitioners must disclose the following to the Director-General of ACT Health and Community Services Directorate **within seven days** after the practitioner becomes aware of:

- any adverse finding made against the practitioner
- any change to the practitioner's registration as a health practitioner, and
- any notification made about the practitioner under the *Health Practitioner Regulation National Law (ACT)*.

Authorised practitioners must disclose the following to the Director-General of ACT Health and Community Services Directorate **within 14 days** after the practitioner becomes aware of the following event or circumstance:

- a change to the authorised practitioner's name
- a change to the authorised practitioner's contact details, and
- a change to the authorised practitioner's eligibility to be an authorised practitioner.

Authorised practitioners can notify the Director-General by emailing VADWorkforce@act.gov.au

2.6 Recording interactions about voluntary assisted dying

2.6.1 Documenting in the health record

When a person makes a request for voluntary assisted dying to a health practitioner, the health practitioner must document this request in the person's health record within the health information system used in the facility where they practice. This must include:

- the day the request was made
- their decision to accept or refuse the request, and
- If the practitioner refuses the request, they must document that they informed the person that:
 - a) other health practitioners may be able to assist with their request; and
 - b) whether they gave the person the details of the VAD-CNS or another authorised practitioner.

Health professionals are bound by professional and statutory obligations relating to privacy and confidentiality and must only ever access the health records for patients to whom they are providing direct care. This is a requirement of the *Health Records (Privacy and Access) Act 1997*.

2.6.2 Documenting in the online portal

An online portal has been developed to guide authorised practitioners through the voluntary assisted dying process and to comply with the reporting requirements under the Act.

Each step in the voluntary assisted dying process requires the lodgment of a form to the Board within a specified timeframe. The online portal has been developed to streamline this process for authorised practitioners. Authorised practitioners must still record relevant clinical information in the person's health record within the health information system used in the facility where they practice.

In addition to meeting reporting requirements, authorised practitioners should ensure timely and accessible communication of the next steps to the person and their chosen support people, using language and formats suited to their needs.

The list of approved forms for the voluntary assisted dying process and the required timeframe for submission to the Board is detailed in [Section 7: Appendices and resources](#).

3. Conscientious objection

Any health professional can refuse to take part in any stage of the voluntary assisted dying process and has the right to refuse to:

- act as an authorised practitioner for a person
- participate in the request and assessment process
- participate in an administration decision
- prescribe, supply or administer an approved voluntary assisted dying substance
- be present when an approved substance is administered
- provide information about the voluntary assisted dying process, and
- provide advice to an authorised practitioner in relation to a referral made for expert opinion.

If a health practitioner, social worker or speech pathologist has a conscientious objection or refuses to participate in the process for any other reason, they must tell the person as soon as possible. They must also provide the person with the contact details for the VAD-CNS in writing as soon as possible and within two business days of refusing to participate.

Where a health professional has expressed a conscientious objection to voluntary assisted dying, they must continue to provide comprehensive person-centred care or arrange for transfer of care to another appropriately qualified health professional.

4. Supports and self-care for health professionals

4.1 Voluntary Assisted Dying Community of Practice

Connecting with other health professionals who are involved in providing voluntary assisted dying services can assist with managing challenging aspects of this work.

The ACT Voluntary Assisted Dying Community of Practice is an inclusive forum offering practical and emotional support to health professionals, opportunities to learn from peers and seek guidance from senior practitioners.

Health professionals can access the ACT Voluntary Assisted Dying Community of Practice by contacting the VAD-CNS.

4.2 Support for health professionals

Caring for people at the end of their life can be emotionally challenging. Health professionals need to manage the needs and expectations of people and their families. Practising self-care is an important part of participating in the voluntary assisted dying process.

Respect for diverse beliefs among colleagues and within teams should also be promoted to ensure a safe and supportive work environment when participating in or opting out of the voluntary assisted dying process.

Table 2: Resources for health professionals

Organisation	Resources
End-of-life essentials	<u>End of Life Essentials</u> is a Commonwealth funded project under the National Palliative Care Grant that operates out of Flinders University. It offers free online modules on topics such as <i>Death as a Normal Part of Life</i> , <i>Communication When Death is Imminent</i> , and others, all aimed at health professionals in the acute care sector who interface with end-of-life patients at any stage of the continuum.
End-of-life essentials	<u>End of Life Essentials</u> is a Commonwealth funded project under the National Palliative Care Grant that operates out of Flinders University. It offers free online modules on topics such as <i>Death as a Normal Part of Life</i> , <i>Communication When Death is Imminent</i> , and others, all aimed at health professionals in the acute care sector who interface with end-of-life patients at any stage of the continuum.

CareSearch Palliative Care Knowledge Network	CareSearch Palliative Care Knowledge Network is a website which provides information about self-care strategies and protective practices for those who work in palliative care or end-of-life care. It includes a self-care training module and self-care plan template.
End of Life Direction for Aged Care (ELDAC)	ELDAC provides information, guidance, and resources to health professionals and aged care workers to support palliative care and advance care planning to improve the care of older Australians.
End of Life Law for Clinicians (ELLC)	ELLC is an online training program for medical practitioners and students, nurses and allied and other health professionals that focuses on the law relating to end of life decision-making.
Employee Assistance Program	Health professionals employed by the ACT Health and Community Services Directorate, or Canberra Health Services can access the Employee Assistance Service for free, confidential counselling.
Capital Health Network (CHN) Employee Assistance Program for primary health	CHN provides access to free and confidential counselling for those working in general practices, pharmacies and allied health settings through AccessEAP . Call AccessEAP on 1800 818 728 or book online here . Ask them to charge the appointment to "CHN Medical Practice".
Australian College of Rural and Remote Medicine (ACRRM) Practitioner Health and Wellbeing resources	The ACRRM website provides a number of external resources for physical and mental health and other concerns. ACRRM's Employee Assistance Program can provide 24/7 support by calling 1800 818 728.
DRS4DRS Australian Capital Territory	A not-for-profit subsidiary of the Australian Medical Association, DRS4DRS contains useful general resources related to the health and wellbeing of doctors. ACT specific helpline is 1300 374 377
Royal Australasian College of Physicians (RACP)	Reach out to the RACP Support Program for free, 24/7, completely confidential support. Make an appointment or speak with a consultant on 1300 687 327 (Australia).
Royal Australasian College of Physicians (RACGP) Resources	The GP Support Program is a free service available to all RACGP members. It provides professional advice and support with managing a range of issues including conflict, grief and loss, anxiety and depression, and substance use. Call 1300 361 008 during business hours to make an appointment. See additional support resources for GPs Self-care and mental health resources
Royal Australian and New Zealand College of	The RANZCP website provides a number of external resources for physical health, mental health and other concerns.

Psychiatrists (RANZCP) Wellbeing Support	Confidential advice is also available to all members of RANZCP through its Member Welfare Support Line.
Australian College of Nurse Practitioners Peer Support	The Australian College of Nurse Practitioners will provide all nurse practitioners involved in voluntary assisted dying with mentors and/or peer support. Contact admin@acnp.org.au for more information.
Australian Primary Care Nurses Association (APNA) Nurse Support	APNA runs a Nurse Support Line which provides professional support, guidance, and referrals for APNA members. Operates Monday to Friday, 9am to 5pm. Call 1300 303 184 or 03 9322 9598. Email: nursesupport@apna.asn.au APNA suggests its members contact Nurse and Midwife Support (see Nursing and Midwifery Board of Australia Nurse and Midwife Support below) if they need ongoing counselling.
Cancer Nurses Society of Australia Nurse Practitioner Specialist Practice Network	<u>The Cancer Nurse Practitioners Specialist Practice Network</u> provides networking opportunities and support from peers working at a senior clinical level to nurse practitioners who are members.
Nursing and Midwifery Board of Australia Nurse and Midwife Support	<u>The National Nurse and Midwife Support Organisation</u> , supported by the Nursing and Midwifery Board of Australia, provides several resources for health and wellbeing. They also provide resources for dealing with compassion fatigue.
Pharmacist Support Service	<u>The Pharmacist Support Service</u> is a free service run by pharmacists for pharmacists. The service provides a listening ear over the phone to pharmacists, pharmacy interns and students. The focus is support, empowerment and information provision.

Table 3: General resources for mental health and wellbeing

Organisation	Resources
Australian Centre for Grief and Bereavement	Provides support, advice and recommendations for practitioners, to enhance their capacity to provide support to people experiencing bereavement, which may be useful for people accessing voluntary assisted dying and their families (fees apply). Call 1800 642 066 or visit the Grief Australia website.
BeyondBlue	Information and support to help individuals experiencing anxiety and depression.

Call 1300 224 636 or visit the [BeyondBlue website](#).

**CRANA plus
Bush Support Line**

A free telephone counselling and support service for health workers (and their families) in rural and remote areas.

Call 1800 805 391 or visit the [CRANA plus website](#).

Lifeline

24/7 crisis support and suicide prevention.

Call 13 11 14 or visit the [Lifeline website](#).

**Palliative Care Australia
Self-Care Matters**

A [resource](#) to support health practitioners providing palliative care, including the Self-Care Matters planning tool and mindfulness and meditation exercises.

ReachOut.com

[Resources](#) for developing a self-care plan, including a template.

**TEN – The Essential
Network for Health
Professionals (Black Dog
Institute)**

A [range of resources](#) for health practitioners, including mental health self-assessment, confidential online courses, resources for managing burnout, and professional peer support and mentoring.

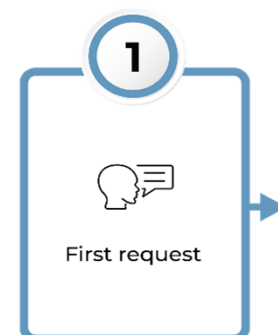
Section 4:

The voluntary assisted dying process

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1. First request

A person may make a request for voluntary assisted dying to any health practitioner, however, only an authorised practitioner can accept the request. The first request must be clear and unambiguous, made by the person and not by an agent acting on their behalf. The person can use any method of communication they are able to use, including sign language or assisted communication devices to make their first request.



After receiving a first request, a health practitioner must decide to accept or decline the person's request. This must occur within **4 business days** after receiving the first request, and they must inform the person of their decision.

The voluntary assisted dying process starts when an authorised practitioner accepts a person's first request. The authorised practitioner then becomes the person's coordinating practitioner. This is the first of 3 requests required to complete the voluntary assisted dying process. There is no minimum timeframe between the first and final request.

If a health practitioner declines the first request, they must provide the details of an authorised practitioner they believe would be able to assist them or the contact details for the VAD-CNS. They must record the action taken and their decision in the person's health record. If the first request is made to a health practitioner who is not authorised, they must decline the request and follow the steps described above.

If a health practitioner has a conscientious objection, they must tell the person as soon as possible. They must also provide the person with the contact details for the VAD-CNS in writing within **2 business days** of declining the request. They must record the action taken in the person's health record.

1.1 Examples of a valid first request

People do not have to use the words "voluntary assisted dying" in their first request. The table below has some examples of statements people might use when making their first request for voluntary assisted dying.

Table 1: Examples of a valid first request for voluntary assisted dying

Examples of a valid first request	Examples that would not be considered a valid first request
"I want you to help me die."	"I'm tired of life. I've had enough."
"How can I get medication to end my life?"	"Can you tell me more about voluntary assisted dying?"
"Can I access euthanasia?"	"Does this hospital/facility provide voluntary assisted dying?"

To determine if a person is making a valid first request, the authorised practitioner should:

- carefully explore what the person is asking with curiosity and respect
- seek to understand what the person wants from them
- show empathy to the experience of distress or suffering and ask clarifying questions
- confirm the person's understanding of their diagnosis and prognosis, palliative care and other treatment options available to them
- explore the reasons they wish to access voluntary assisted dying, and
- determine their end of life care preferences, with respect to their beliefs and cultural considerations.

1.2 Documenting a first request

The health practitioner must document a first request in the person's health record, and the online portal. The health practitioner must document:

- if they accept or decline the request
- if they declined the request, what information they provided to the person, such as details of the VAD-CNS or another health practitioner they believe could assist the person, and
- the date the request was made.

1.3 Providing the *First request information*

Upon accepting a person's first request for voluntary assisted dying, the coordinating practitioner must provide the person with the *First request information*. The information pack details:

- the voluntary assisted dying process
- palliative and end of life care options
- supports available to the person, carers and family, and
- forms that must be completed.

2. First assessment

There is no minimum timeframe in the Act between the first request and first assessment. The first assessment can immediately follow a first request. It can occur during the same consultation if this aligns with the person's preference, coordinating practitioner's availability, and other factors such as the person's prognosis.

There may be times when it is necessary to temporarily pause the assessment process to be able to definitively determine a person's eligibility.



It is important to set expectations early, explaining that completing an eligibility assessment may require more than one appointment.

During the first assessment, the coordinating practitioner should seek to understand the person's stage in their end of life journey. This includes determining whether they are firm in their plans to access voluntary assisted dying or if they are still considering their options for end of life care.

2.1 Eligibility criteria to access voluntary assisted dying

During the first assessment, the coordinating practitioner must assess if the person meets the following eligibility criteria:

- aged 18 years of age or older
- resident of the ACT for at least the last 12 months
- diagnosed with a relevant condition that is advanced, progressive and expected to cause death
- experiencing intolerable suffering
- has decision making capacity, and
- the request is made voluntarily and without coercion.

2.1.1 Age

The person must be **18 years of age or older** at the time of their first request. If supporting documents are needed to verify the person's age, this may include their birth certificate, driver licence, or a current passport.

It is the authorised practitioner's responsibility to verify the person's age and residency status during the first and consulting assessments.

2.1.2 Residency

The person must have lived in the **ACT for the last 12 months** at the time of their first request. They must share supporting documents such as utility bills, rental agreements or bank statements to verify this.

If the person does not meet the residency requirements, they may apply for an exemption if they can demonstrate a **substantial connection to the ACT**. Examples of this may include:

- living in a place close to the ACT border and is either working in the ACT or receiving medical treatment in the ACT
- they are an Aboriginal or Torres Strait Islander person and wish to die on Country
- they have moved to the ACT so that family, friends or carers who live in the ACT can provide care and support

- they have lived in the ACT for less than 12 months but have been diagnosed with their relevant condition after moving to the ACT, and
- they have previously lived in the ACT and their family, friends or carers still live in the ACT.

Applications for an exemption can be submitted on the ACT Government website. When discussing voluntary assisted dying with a person who is looking to apply for a residency exemption, it is important to make clear to the person that **all steps of the process must occur in the ACT**, including administration of the approved voluntary assisted dying substance. The substance cannot be taken outside of the ACT.

Table 2: Examples of documentation to support eligibility against demographic criteria

Demographic criteria	Examples of supporting documentation
18 years or older	passport birth certificate driver licence proof of identify card
Lived in the ACT for at least 12 months at the time of first request	bank statements medical records utility bills rental agreement statement from an authorised person from a residential care facility

2.1.3 Diagnosed with a condition that is advanced, progressive and expected to cause death

The person must have been diagnosed with a condition that either on its own, or in combination with other diagnosed conditions, is advanced, progressive and expected to cause death.

The Act differentiates a condition which is advanced, progressive and expected to cause death from **disability, mental disorder or mental illness**. A person does not meet these requirements **only** due to having:

- a disability that substantially impairs their communication, learning or mobility which results in the person needing support services to live with the disability, or
- a mental disorder or mental illness.

People with disability, mental disorder or mental illness, like others in the community, must meet all eligibility criteria to access voluntary assisted dying. For a person with a mental disorder or mental illness, this in isolation does not qualify as a relevant condition.

Similarly, a person with a disability will not have a relevant condition only because their disability results in the person needing services to support them to live with their disability.

2.1.3.1 Exploring the definition of advanced

A condition is **advanced** if:

- the person's functioning and quality of life is deteriorating and not expected to improve
- any treatments for the conditions that are reasonably available and acceptable to the person have lost any beneficial impact, and
- the person is approaching the end of their life.

When determining if treatments have lost any beneficial impact, authorised practitioners should explore the purpose and expected outcomes of available treatments with the person, and if they consider these to be beneficial to their quality of life.

Under the Act, treatment for the conditions does not include treatment that is primarily for the purpose of relieving symptoms or for the purpose of relieving any pain or distress caused by the conditions.

A treatment is not necessarily beneficial to a person even if it is expected to have clinically beneficial outcomes. Emphasis must be placed on the impact treatments are having on the person's quality of life, and the person's own determination of whether a treatment remains beneficial. For example, a person with metastatic cancer may be referred for further chemotherapy to reduce tumour burden and extend prognosis. The person determines the impact of continued chemotherapy on their quality of life, and therefore whether it remains to be beneficial.

Approaching end of life

Unique to the ACT, is the absence of required timeframes to death in the eligibility criteria. Instead, authorised practitioners must consider the person to be approaching the end of their life.

Prognostication during end of life care can be imprecise and it is common to feel uncertain about the person's trajectory when there is advancing illness. Authorised practitioners should consider the person's diagnosis, expected disease trajectory, desire to continue or cease treatments and their individual experience of suffering, when determining if a person is approaching the end of their life.

Approaching end of life does not only extend to people whose death is imminent and expected within a few hours or days. Similarly, a person who is diagnosed with a terminal condition that is expected to deteriorate over the course of years would not be approaching the end of their life.

For the purposes of accessing voluntary assisted dying in the ACT, a person with an advanced, progressive condition, who is experiencing intolerable suffering because of their condition or treatment, or a combination of both, may be approaching end of life, **even if it is uncertain whether their condition will cause death within 12 months.**

Resources to assist authorised practitioners in recognising end of life have been included in [*Section 7: Appendices and resources*](#).

2.1.3.2 Progressive

A condition is **progressive** if a person's condition is deteriorating and will continue to deteriorate.

2.1.4 Intolerable suffering

The person's condition or medical treatment is causing suffering that is persistent, and in the person's opinion, intolerable.

Persistent and intolerable suffering can be:

- physical or mental, existential or any combination of these
- caused by the condition on its own, or in combination with any other diagnosed conditions
- caused by the treatment for the condition, or in combination from treatments for any other diagnosed conditions
- anticipated to occur due to the condition or treatment based on medical advice, and
- caused by a medical complication that may result from the condition or treatment.

This is a purposely broad definition to reflect that end of life suffering is complex and can be caused by more than just the symptoms of a person's condition.

Suffering is a **subjective** experience that is judged by the person themselves.

While a practitioner is required to determine that a person has an incurable condition, it is the person themselves who determines whether their suffering is intolerable.

Authorised practitioners should be prepared to encounter some reluctance or refusal to discuss suffering among certain groups in the community. This can be common among people who have experienced trauma; those with a stoic nature; and people who interpret, process and communicate information differently. For these individuals, it can be helpful to ask open-ended questions to help to determine suffering such as "why do you want voluntary assisted dying to be part of your end of life care?".

2.1.5 Decision-making capacity

A person must have decision-making capacity during all steps of the voluntary assisted dying process. Capacity is a legal term referring to the person's ability to make decisions, in this case, those relating to their medical treatment.

An adult is **assumed to have decision-making capacity** in relation to voluntary assisted dying unless there is evidence to suggest otherwise. A person's current decision-making capacity should not be determined by their personal characteristics or disability, illness or history of trauma.

Decision-making capacity for voluntary assisted dying means a person must be able to do the following at each step of the process:

- understand the facts that relate to a decision about voluntary assisted dying, such as the nature of their condition and their prognosis
- understand the main choices available to them
- understand and weigh up the consequences of each choice or option
- understand that taking the approved voluntary assisted dying substance will result in their death, and
- make a decision on the basis of the choices or options available and communicate their decision by speech, gestures or any other means.

Factors to consider when deciding if a person has decision-making capacity in relation to voluntary assisted dying:

- a person must be assumed to have decision making capacity, unless it is determined that they do not meet the threshold
- a person's decision-making capacity is particular to the decision they are to make
- if a person is capable of making the decision with adequate and appropriate support, they are capable of making a decision
- a person must not be treated as not having decision-making capacity, unless all practicable steps to support them to make decisions have been taken
- a person must not be treated as not having decision-making capacity because they make an unwise decision or have impaired decision-making capacity under another Act, or in relation to another decision, and
- a person who fluctuates between having and not having decision-making capacity must be given the opportunity to consider matters requiring a decision at a time when they have decision-making capacity, if practicable.

Decision-making capacity can fluctuate over time. There may be instances where a person temporarily loses capacity and regains it later. This can occur because of taking certain medications (e.g. benzodiazepines, opioids or other sedatives) or from delirium experienced due to other illnesses or conditions (e.g. infection or trauma). A person should be given the opportunity to consider matters at a time when they have decision-making capacity.

Decision-making capacity can also be influenced by the:

- complexity of the decision
- time and context in which the decision is being made, and
- supports available to the person such as carers, family, cultural supports and advice from health professionals.

When completing an assessment of a person's decision-making capacity, the authorised practitioner should select a time when the person's symptom control is optimal, and they are not overly tired or experiencing any adverse effects from medication.

A person's decision-making capacity is specific to the decision they need to make. A person who has made an unwise decision, or who has been found to have impaired

decision-making capacity in another circumstance, may still have decision-making capacity in relation to voluntary assisted dying.

Before it is determined that a person does not have decision making capacity, all practical steps must be taken to support them to make a decision. Examples of support may include:

- giving information to the person in a way that is tailored to their needs
- assisting a person to communicate their decision, e.g. with the assistance of an interpreter, speech pathologist, or occupational therapist
- giving additional time, and
- using technology that alleviates the effects of a person's disability.

Authorised practitioners may find it useful to use a capacity and consent tool to guide discussions. There are no validated tools specific to assessing decision-making capacity in relation to voluntary assisted dying. Table 3 may be helpful in framing a decision-making capacity assessment, provided the person has been adequately informed of the voluntary assisted dying process in a way they understand.

Table 3: Assessing decision-making capacity in relation to voluntary assisted dying: possible approaches and red flags

Criteria	Person's responsibility	Practitioner's assessment	Prompts for clinical assessment	Red flags – requires further investigation
Understand the facts that relate to the person's decision about accessing voluntary assisted dying, such as the nature of their condition and their prognosis.	Understand their current health condition and prognosis.	Ask the person to describe in their own words their medical condition and prognosis.	Please tell me in your own words: - Why are you thinking about accessing voluntary assisted dying? - Can you tell me about your health condition/s? - What do you know about your life expectancy?	Person fails to understand their medical condition. Person does not acknowledge their condition, e.g. lacking insight because of delusions or denial. Person cannot remember or is unclear about their medical condition/s.
Consider voluntary assisted dying in the context of other end of life options, including palliative care.	Understand the various options – such as treatment and palliative care options and voluntary assisted dying.	Ask the person to describe in their own words the palliative care and treatment options, and the steps in the voluntary assisted dying process.	Please tell me in your own words: - What are the palliative care and treatment options available to you? - How did you come to your decision? - What makes voluntary assisted dying the best option for you?	Person fails to understand the possible palliative care and treatment options and their consequences. Person cannot remember or is unclear about: - possible treatment options, and - the voluntary assisted dying process.
Understand and weigh up the consequences of the main choices available to them.	Understand that voluntary assisted dying will lead to their death. Understand the consequences of the treatment options and likely outcomes. Understand the consequences of the palliative care options and likely outcomes.	Ask the person to describe in their own words the consequences of the palliative care and treatment options, and the outcome of voluntary assisted dying.	Please tell me in your own words about: - What are the risks and benefits of not receiving treatment? - Can you explain what you expect to happen if you receive access to voluntary assisted dying.	Person fails to understand the possible palliative care and treatment options and their consequences. Person cannot understand that voluntary assisted dying will lead to their death.

2.1.6 The request must be made voluntarily and without coercion

Throughout the voluntary assisted dying process, authorised practitioners should seek to understand the reasons why the person is requesting voluntary assisted dying. These conversations will give insight into why the person thinks accessing voluntary assisted dying is the best end of life option for them.

Assessing for indicators of coercion should initially occur by talking with the person on their own. If appropriate, and with the person's consent, the authorised practitioner can explore the person's wish to access voluntary assisted dying with their carers, family, general practitioner or treating team. These discussions may provide useful insights into the motivation behind the person's decision.

Many people will seek advice from others before they come to a decision. The focus is on whether the person can make a decision free of intimidation or pressure.

Indicators of coercion may include:

- excessive deference by the person to carers, family or friends for answers, reassurance or explanation
- carers, family or friends talking over the person and answering on their behalf
- inconsistencies in the person's answers to questions about their suffering, illness experience or voluntary assisted dying in general, and
- carers, family or friends threatening to withdraw care and support from the person.



Table 4: Example questions to explore coercion

- Are you feeling any pressure from others to request voluntary assisted dying?
- Do you have any significant financial concerns that may be contributing to your suffering?
- Do you feel safe with your family/partner/carer right now?
- Is there anything we discuss that you don't want your family to know?
- Tell me about your relationship with your family or friends (may include partners, spouse, children, parents, siblings).
- Is your family aware of your request for voluntary assisted dying?
- Do they support your decision to access voluntary assisted dying?
- Is your medical practitioner aware of your request for voluntary assisted dying?
- Does your medical practitioner/family/partner/carer support you having discussions about voluntary assisted dying?
- Are you feeling any pressure from others to either request or not request voluntary assisted dying?

Some people may feel they are a burden because family members are struggling to provide care and financial resources. Authorised practitioners should query why the person has raised this concern, what they mean by it and explore options for supportive or respite care.

If an authorised practitioner is concerned that a person requesting voluntary assisted dying thinks they are a burden on their carers or family, and that this may be influencing their decision to request voluntary assisted dying, they should investigate for indicators of coercion.

If the authorised practitioner is not satisfied the person's request is voluntary and free from coercion, they must assess the person as not eligible for voluntary assisted dying at that time.

If there is concern the person may be experiencing domestic and family violence, financial abuse, elder or any other forms of abuse, it is imperative that a safe, appropriate, and timely response is provided separately from the voluntary assisted dying process.

The [ACT Domestic and Family Violence Risk Assessment Framework](#) can assist authorised practitioners to screen, assess and manage risk of domestic and family violence. Alternatively, ACT Disability, Aged Care, and Carer Advocacy Service can be contacted. Details are available on their website [Home - ADACAS](#).

Complaints about abuse, neglect or exploitation of a vulnerable person can be made to the Human Rights Commission on their website [Complaints about Abuse, Neglect or Exploitation of Vulnerable Canberrans - HRC](#). Complaints can also be made if you think a vulnerable person is at risk of abuse, neglect or exploitation.

2.2 Providing information and confirming understanding

If the coordinating practitioner decides the person satisfies the eligibility criteria, the practitioner must provide them with specific information. This must occur before making an eligibility determination.

Information must be provided to the person about their diagnosis, prognosis, treatment and palliative care options. This information can be provided verbally. The authorised practitioner must confirm the person understands the information before assessing them as eligible for voluntary assisted dying.

The *Assessment checklist* in Table 5 has been developed to assist practitioners to achieve this requirement.

Table 5: Assessment checklist

Information that must be provided to the person by the coordinating and consulting practitioner	
☐	The person's diagnosis and prognosis.
☐	Treatment options available to the person and likely outcomes.
☐	Palliative care options available to the person and likely outcomes.
☐	That the person can choose between self-administration or practitioner administration of the approved voluntary assisted dying substance.
☐	Potential risks of self-administering or being administered the approved voluntary assisted dying substance.
☐	That the expected outcome of self-administering or being administered the approved voluntary assisted dying substance is death.
☐	The voluntary assisted dying process, including the requirement for the second request to be signed in the presence of two eligible witnesses.
☐	That the person may decide at any time to not proceed with voluntary assisted dying.
☐	That the person may wish to tell their other treating health practitioners that they have made a request to access voluntary assisted dying.

The coordinating practitioner must be satisfied the person understands the information provided to them before assessing the person as eligible for voluntary assisted dying. It may take more than one appointment to discuss the information detailed in the *Assessment checklist* and to confirm the person understands.

When deciding if the person demonstrates understanding of the information provided to them, the coordinating practitioner must consider:

- that a person who understands the information with support should still be considered as capable of understanding the information
- before deciding a person does not understand the information, they must take all practicable steps to support them to understand the information provided
- that a person who moves between understanding and not understanding the information must be given the opportunity to consider the information at a time when they are most likely to understand it, and
- that if a person demonstrates impaired judgement or decision making in other aspects of their life, this should not be solely relied on to assume the person does not understand the information.

Once the coordinating practitioner is comfortable the person meets the eligibility requirements and understands the information given to them, the person is assessed as eligible for voluntary assisted dying, and they can proceed with the next step of the process.

2.3 Administrative tasks

Once the coordinating practitioner completes the first assessment, they must within **4 business days**:

- complete the *First assessment report* in the online portal
 - this should include any documents relevant to their decision
- inform the person of the outcome of the first assessment, and
- provide them with a hard copy of the report.

2.4 When a person has been found not eligible for voluntary assisted dying

A person who has been found not eligible for voluntary assisted dying may find it hard or distressing, especially if they feel their suffering cannot be relieved in any way they consider tolerable. The coordinating practitioner should:

- advise the person that they can make a new first request to a different authorised practitioner, or they can make a new first request to their coordinating practitioner if their circumstances change
- provide the person with the If You Are Found Not Eligible for Voluntary Assisted Dying information sheet
- acknowledge the distress the person feels about being found not eligible for voluntary assisted dying
- advise that the person's eligibility may change if their condition deteriorates
- clearly explain why they are not eligible for voluntary assisted dying at this time, answer any questions they may have about the eligibility criteria and reasons for the outcome
- discuss treatment options that may ease suffering by managing physical symptoms, psychosocial or spiritual distress
- refer to relevant healthcare workers to provide psychosocial support, this may include social workers, psychologists, Aboriginal and Torres Strait Islander Health Liaison Officers, and
- refer people who have advanced conditions with complex needs to a specialist palliative care team if they are not already involved in the person's care.

A person who has been found not eligible for voluntary assisted dying should be assessed for risk of suicide. The coordinating practitioner should ask the person if they have any suicidal thoughts, plans or methods. If a risk of suicide is identified, the coordinating practitioner must arrange an urgent mental health assessment with the relevant crisis team through Access Mental Health. Other services who can help include:

- [Lifeline](#)
- [Beyond Blue](#)
- [13YARN](#)

2.5 Transferring the coordinating practitioner role

2.5.1 Transfer initiated by the coordinating practitioner

The coordinating practitioner can transfer their role to another authorised practitioner if they are unable or unwilling to continue the voluntary assisted dying process with a person. The person must give their consent before the coordinating practitioner can refer them to another authorised practitioner to continue the process.

After receiving a referral to become the new coordinating practitioner, the authorised practitioner must decide whether to accept the referral and advise the original coordinating practitioner within 4 business days.

If the authorised practitioner declines the referral, the original coordinating practitioner must take reasonable steps to find an alternative authorised practitioner or give the person the contact details for the VAD-CNS.

If the authorised practitioner accepts the referral, the original coordinating practitioner must:

- inform the person
- document this in the person's health record
- complete the *Transfer of practitioner* form in the online portal
 - this must happen within **4 business days** after informing the person of the transfer and will automatically notify the Board, and
- advise the new coordinating practitioner that the Board has been notified.

Once the Board has been notified, the new authorised practitioner becomes the person's coordinating practitioner, and all responsibilities are transferred. Any decisions made by the original coordinating practitioner in relation to a person's eligibility for voluntary assisted dying are enduring.

2.5.2 Transfer initiated by the person

A person can ask another authorised practitioner to become their coordinating practitioner at any time in the process.

The new authorised practitioner must decide whether to accept the role within 4 business days. If they accept the role, they must:

- inform the person
- inform the original coordinating practitioner, and
- complete the *Transfer of practitioner* form in the online portal

- this must happen within **4 business days** after informing the person about the transfer and will automatically notify the Board.

The new authorised practitioner should document this change in the person's health record.

If the authorised practitioner declines, they must give the person the contact details for the VAD-CNS.

Once the Board has been notified, the new authorised practitioner becomes the person's coordinating practitioner, and all responsibilities are transferred. Any decisions made by the original coordinating practitioner in relation to a person's eligibility for voluntary assisted dying are enduring.

3. Consulting assessment

The consulting assessment is the second assessment of the person's eligibility in the voluntary assisted dying process. The consulting assessment is completed by a second independent authorised practitioner.

3.1 Referral for a consulting assessment

If the coordinating practitioner determines the person to be eligible for voluntary assisted dying, they must make a referral for a consulting assessment. This must happen as soon as possible, and within **4 business days**, following the coordinating practitioner's determination of the person's eligibility during the first assessment.

The referral for a consulting assessment can be made directly to another authorised practitioner or through the VAD-CNS.

The consulting practitioner role is described in [Section 3: Information for health professionals](#).

3.1.1 Administrative tasks

If the authorised practitioner accepts the referral, within 4 business days they must:

- document the details of the referral in the person's health record, including the date the referral was received, and their decision to accept the referral
- complete the Accept or refuse consulting assessment referral form in the online portal, and
 - this will automatically notify the Board
- advise the coordinating practitioner of their decision to accept the role. The coordinating practitioner must then inform the person as soon as possible.

Once these steps are complete, the authorised practitioner becomes the person's consulting practitioner.



If the authorised practitioner **declines** the referral, within **4 business days** they must:

- inform the coordinating practitioner
- document the referral and their decision in the person's health record, and
- complete the Accept or refuse consulting assessment referral form in the online portal.

If the authorised practitioner **declines** the referral, the coordinating practitioner must tell the person and take reasonable steps to find an alternative authorised practitioner or give the person the contact details for the VAD-CNS.

3.2 Consulting assessment

Following acceptance of a referral, the consulting practitioner must independently assess the person against the eligibility requirements.

The process for completing the consulting assessment is the same as the first assessment. The consulting practitioner must also determine whether the person understands the information provided to them in the *Assessment checklist*.

Once the consulting practitioner is comfortable the person meets the eligibility requirements and understands the information given to them, the person is **eligible** and can proceed with the next step of the voluntary assisted dying process.

If the consulting practitioner decides the person is not eligible for voluntary assisted dying, the coordinating practitioner may refer the person to a different consulting practitioner.

3.2.1 Administrative tasks

Once the consulting practitioner completes the consulting assessment, they must within **4 business days**:

- complete the *Consulting assessment report* in the online portal
 - this should include any documents relevant to their decision
- provide the coordinating practitioner with a copy of the report
- inform the person of the outcome of the consulting assessment, and
- provide them with a hardcopy of the report.

3.3 Seeking an expert opinion

If the coordinating or consulting practitioner is unable to decide whether the person meets a certain eligibility requirement for voluntary assisted dying, they must seek an opinion from a relevant specialist.

The relevant specialist does not need to be an authorised practitioner and does not need to be a doctor or nurse practitioner, so long as the authorised practitioner is of the opinion that the relevant specialist has the appropriate skills and training to provide the advice needed. The authorised practitioner must get consent from the person to share their personal health information with the relevant specialist.

The coordinating or consulting practitioner must not use a relevant specialist who the practitioner knows or believes:

- is a family member of the person
- is a beneficiary under the will of the person
- will benefit from the person's death other than by receiving reasonable fees for service, or
- will benefit from assisting the person to access voluntary assisted dying other than by receiving reasonable fees for service.

The authorised practitioner should attach a copy of any documents relevant to their decision of eligibility when uploading to the online portal. This includes any written advice from a specialist, the person's healthcare team and clinical test results.

3.4 Referral for a further consulting assessment

If the consulting practitioner decides that a person does not meet the eligibility requirements, the coordinating practitioner may refer the person to another authorised practitioner for a further consulting assessment.

Refer to [section 3.1.1](#) for the administrative tasks associated with this process.

4. Second request

The second request is a written declaration made by the person to re-affirm their intention to access voluntary assisted dying. A second request can only be made once the person has been found eligible for voluntary assisted dying in their first and consulting assessments.

The second request must:

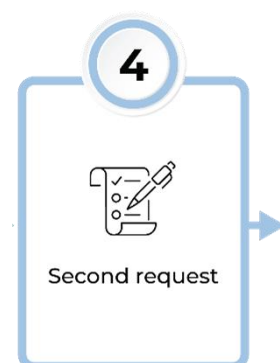
- be made in writing and signed by the person, or by an agent acting on their behalf
- declare that the request is made voluntarily, without coercion and the person understands the nature and effect of the request, and
- be witnessed by two eligible people certifying that the request was signed by the person in the presence of the witnesses.

The coordinating practitioner does not need to be present when the second request is signed and witnessed but must be provided with a copy of the request.

4.1 Administrative tasks

Within **4 business days** of receiving a completed a second request, the coordinating practitioner must:

- document in the person's health record, including the date the second request was signed and received, and



- complete the in the online portal. This will prompt the coordinating practitioner to upload a copy of the completed second request.

4.2 Witnessing the second request

Any person is eligible to be a witness for the second request if they:

- are 18 years of age or older
- are not a beneficiary under the person's will, and do not believe they will benefit in any other way from the person's death or their access to voluntary assisted dying
- do not own or manage a facility where the person lives or is being treated, and
- are not the person's coordinating or consulting practitioner.

4.3 Using an agent

If the person making the second request cannot sign it themselves, they can have an agent sign it on their behalf. An agent must:

- be 18 years of age or older
- not be a witness to the signing of the request, and
- not be the person's coordinating or consulting practitioner.

Using an agent to sign the second request must happen in the presence of the person requesting voluntary assisted dying and in the presence of two witnesses.

The witnesses must certify that the person appeared to ask the agent to sign the request, voluntarily and without coercion. The witnesses must also certify that they are not knowingly an ineligible witness.

5. Final request

After the person has made their second request, they can make a final request to their coordinating practitioner to access voluntary assisted dying. There is **no minimum timeframe** in the Act between the second request and final request.

The final request must be:

- made by the person
- clear and unambiguous, and
- made in writing, verbally, or in any way the person can communicate.

The person can use any method of communication they are able to use, including sign language or assisted communication devices to make their final request. The final request must not be made by an agent acting on the person's behalf.



5.1 Administrative tasks

The coordinating practitioner must document:

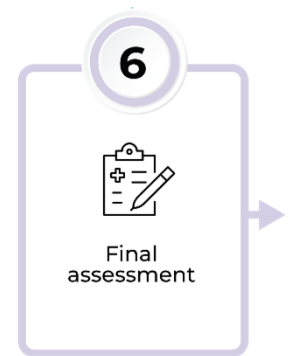
- the date the person made their final request in the person's health record, and
- complete the *Final request* in the online portal as soon as possible but within **4 business days** after the person made their final request
 - this will automatically notify the Board.

6. Final assessment

The final assessment should happen as soon as possible after the person has made their final request and can happen in the same consultation.

The coordinating practitioner is not required to undertake a third assessment of the person's eligibility during the final assessment. However, the coordinating practitioner must re-determine if the person:

- has decision-making capacity in relation to voluntary assisted dying, and
- is acting voluntarily and without coercion.



6.1 Administrative tasks

If the coordinating practitioner is satisfied the person meets these requirements, they must:

- complete the *Final assessment report* in the online portal as soon as possible but within **4 business days** after the practitioner makes their decision
- inform the person of the outcome of the final assessment as soon as possible, and
- provide the person with a copy of the Final assessment report as soon as possible.

7. Administration decision

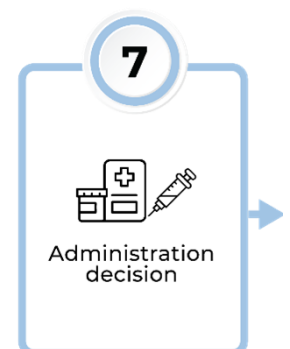
The approved voluntary assisted dying substance can be self-administered or practitioner administered.

The administration decision is made by the person, in consultation with their coordinating practitioner. Any discussions about the administration decision must occur in-person, to avoid any potential breaches of the Criminal Code.

All related discussions must also occur in-person, including discussing the prescription, preparation, and steps to administer the approved voluntary assisted dying substance, and discussing a plan for the day of administration.

The administration decision:

- must be clear and unambiguous
- must be made by the person in writing, verbally or any other way the person can communicate, and



- takes effect when the person tells their coordinating practitioner about the decision.

The person can use any method of communication they are able to use, including sign language or assisted communication devices to convey their administration decision. The administration decision must not be made by an agent acting on the person's behalf.

7.1 Administrative tasks

The coordinating practitioner must document the person's decision for self-administration or practitioner administration in the person's health record, including:

- the planned administration route, e.g. oral, enteral access device, intravenous
- the date the administration decision was made
- any factors that were considered as part of the administration decision, and
- if an interpreter was used.

The coordinating practitioner must complete the *Administration decision* form in the online portal within **4 business days** after the person informs them of their administration decision.

For considerations when making an administration decision, refer to the *ACT Voluntary Assisted Dying Prescription and Administration Manual*.

7.2 Practitioner administration

An administering practitioner can administer the approved voluntary assisted dying substance intravenously or by helping the person take the substance orally or via an enteral access device. People may choose practitioner administration because they cannot take or absorb the substance via their gastrointestinal system, or it may be their personal preference.

7.2.1 Administrative tasks

A person may ask their coordinating practitioner or another authorised practitioner to act as their administering practitioner.

Within **4 business days** of the request the authorised practitioner must:

- decide if they accept the request to act as the administering practitioner
- inform the person of their decision, and
- document the request and their decision in the person's health record.

If the authorised practitioner agrees to act as the administering practitioner, they must complete the *Appointment of administering practitioner* form in the online portal within **4 business days** after the day they inform the person of their decision.

If the authorised practitioner declines, they must tell the person that another authorised practitioner may be able to assist with the request. They must provide the person with details of another authorised practitioner that may be able to assist or advise them to contact the VAD-CNS, and document this in the person's health record.

7.2.2 Administrative tasks for **practitioner initiated** transfer of the administering practitioner role

The administering practitioner can transfer their role to another authorised practitioner if they are unable or unwilling to continue the voluntary assisted dying process with a person. The person must give their consent before the administering practitioner can refer them to another authorised practitioner.

After receiving a referral to become the new administering practitioner, the authorised practitioner must decide whether to accept the referral and advise the original administering practitioner within **4 business days**.

If the authorised practitioner declines, the original administering practitioner must take reasonable steps to find an alternative authorised practitioner or give the person the contact details for the VAD-CNS.

If the authorised practitioner accepts, the original administering practitioner must:

- inform the person, and give them the name and contact details of the new administering practitioner
- document this in the person's health record
- complete the *Transfer of practitioner* form in the online portal, and
 - this must happen within **4 business days** after informing the person of the transfer and will automatically notify the Board
- advise the new administering practitioner that the Board has been notified.

Once the Board has been notified, the new authorised practitioner becomes the person's administering practitioner, and all responsibilities are transferred.

7.2.3 Administrative tasks for **patient initiated** transfer of the administering practitioner role

A person can ask another authorised practitioner to become their administering practitioner at any time in the process.

The new authorised practitioner must decide whether to accept or decline the role within **4 business days**. If they accept the role, they must:

- inform the person
- complete the *Transfer of practitioner* form in the online portal
 - this must happen within **4 business days** after informing the person of accepting the role and will automatically notify the Board
- inform the original administering practitioner of the decision and when the Board has been notified
- inform the coordinating practitioner if they are not the person's the original administering practitioner, and
- document this change in the person's health record.

If the authorised practitioner declines, they must give the person the contact details for the VAD-CNS.

Once the Board has been notified, the new authorised practitioner becomes the person's administering practitioner, and all responsibilities are transferred.

7.3 Self-administration

Self-administration requires the person to take the approved voluntary assisted dying substance orally or to administer it via an enteral access device. This is suitable for people who can ingest and absorb the substance and want to choose the time and location of their death.

Any adult can help to prepare the substance for self-administration, however, the person must take it independently and without assistance. People who require assistance administering using their enteral device or taking the substance orally must choose practitioner administration.

7.3.1 Appointing a contact person

A person who has made a self-administration decision must appoint a contact person. The contact person can be a family member or carer, the coordinating practitioner, consulting practitioner, or any other adult.

The contact person must:

- be 18 years of age or older, and
- consent to being appointed as the contact person.

The contact person is **authorised** to:

- receive the approved voluntary assisted dying substance from the VAD-PS
- be in the possession of the approved voluntary assisted dying substance
- hand over the approved voluntary assisted dying substance to the person
- prepare the approved voluntary assisted dying substance for the person to self-administer, and
- return any unused or remaining substance to the VAD-PS.

The contact person is **responsible** for:

- advising the Board that they have handed over the approved voluntary assisted dying substance to the person, within 4 business days of doing so
- returning any unused or remaining approved voluntary assisted dying substance and the kit to the VAD-PS for disposal
- returning the approved voluntary assisted dying substance and kit to the VAD-PS as soon as possible, and within 14 days of:
 - the person's death from any cause, or
 - a change in contact person where the substance has not been handed over to the person or the new contact person

- revoking an administration decision, where the person has already been supplied with the substance
- informing the coordinating practitioner of the person's death as soon as possible and within **4 business days**.

7.3.1.1 Administrative tasks

The *Contact person appointment* form must be completed by the person accessing voluntary assisted dying and signed by their chosen contact person. The person must then provide the completed form to their coordinating practitioner. The contact person appointment takes effect when the form is given to the coordinating practitioner.

Within **4 business days** of receiving the completed form, the coordinating practitioner must:

- upload the completed *Contact person appointment* form to the online portal
 - this will automatically notify the Board.

Within **4 business days** of uploading the form to the online portal, the coordinating practitioner must:

- give the contact person the *Contact person information*, which describes:
 - the roles, responsibilities and obligations of the contact person, and
 - the support services available to assist the contact person to comply with their obligations.

7.3.2 Changing a contact person

The person can appoint a new contact person at any time in the voluntary assisted dying process, by:

- informing the original contact person in writing
- informing their coordinating practitioner of the change, and
- submitting a new *Contact person appointment* form to their coordinating practitioner.

In the event the original contact person is still in possession of the approved voluntary assisted dying substance, the original contact person must:

- hand over the approved voluntary assisted dying substance to the person or their newly appointed contact person within **2 days** of being asked to do so, or
- return the approved voluntary assisted dying substance to the VAD-PS within **14 days** of the end of their appointment.

If the contact person decides not to continue in their role, they must inform the person in writing. The person accessing voluntary assisted dying must:

- inform their coordinating practitioner, and
- appoint another contact person by submitting a new *Contact person appointment* form to their coordinating practitioner.

7.3.2.1 Administrative tasks

The coordinating practitioner must submit the *Ending appointment of a contact person* form on the online portal within **4 business days** of being advised of the change.

The original contact person must advise the Board in writing that they have handed over the approved voluntary assisted dying substance within **4 business days** of returning it to the person or their new contact person.

Refer to the *Contact person information pack* for further information and guidance on this process.

7.4 Changing an administration decision

There are a range of reasons a person may choose to change an administration decision. For example, if the person has chosen self-administration and is no longer able to independently self-administer. A person can change their administration decision at any time.

The decision to change an administration decision must be:

- clear and unambiguous
- made by the person verbally, in writing, or in any way that the person can communicate, and
- can be made in consultation with or based on the advice of the coordinating practitioner.

A person cannot use an agent to change their administration decision on their behalf.

The change of administration decision takes effect when the person tells their coordinating practitioner about their decision.

7.4.1 Administrative tasks

Once the coordinating practitioner is notified by the person that they wish to change their administration decision, the coordinating practitioner must:

- document this in the person's health record
- complete the *Change of administration decision* form in the online portal within **4 business days** of being advised of the change.

If a person changes their administration decision to self-administration, they must follow the steps described in [section 7.3.1](#) to appoint a contact person.

If a person changes their administration decision to practitioner administration, any previous contact person appointments in effect ends when the decision is changed. The person must follow the steps in [section 7.2.1](#) to appoint an administering practitioner.

7.5 Revoking a decision to proceed with voluntary assisted dying

The person can revoke their decision to proceed with voluntary assisted dying at any time in the process.

If a person has made an administration decision, this revocation takes effect as soon as:

- the person informs their coordinating practitioner that they have decided not to proceed with the self-administration of the approved voluntary assisted dying substance, or
- informs their coordinating practitioner or administering practitioner that they have decided not to proceed with the practitioner administration of the approved voluntary assisted dying substance.

The person can communicate this in writing, verbally or any other way they can.

If the person or their contact person possesses the approved voluntary assisted dying substance when the person revokes their self-administration decision, the person or their contact person must give the substance to the VAD-PS as soon as possible, and within 14 days after the decision was revoked.

If the person revokes their practitioner administration decision, and the administering practitioner possesses the approved voluntary assisted dying substance, the administering practitioner must give the approved voluntary assisted dying substance to the VAD-PS as soon as possible and within 14 days after they were informed the decision was revoked.

7.5.1 Administrative tasks

The coordinating practitioner or administering practitioner must document this change in the person's health record, including:

- the date they were notified, and
- if an interpreter was used.

When the coordinating practitioner or administering practitioner is informed of a revocation in administration decision, they must complete the *Revoking an administration decision* form in the online portal within **4 business days**.

If the administering practitioner is not the person's coordinating practitioner, they must provide written notice to the coordinating practitioner within **4 business days** of being informed of the revocation.

8. Prescription and supply

The coordinating practitioner can write a prescription for an approved voluntary assisted dying substance once the following steps have been completed:

- the final assessment has been completed
- the person has made an administration decision
- a contact person or an administering practitioner has been appointed, and
- they have provided the person with the relevant Patient information booklet and confirmed their understanding.

More information about the requirements for prescription and supply is detailed in the *ACT Voluntary Assisted Dying Prescription and Administration Manual*.



9. Administering the approved voluntary assisted dying substance

See the *ACT Voluntary Assisted Dying Prescription and Administration Manual* (the Manual) for detailed information about the supply and administration of the approved voluntary assisted dying substance.

The Manual will be provided to authorised practitioners upon successful completion of the mandatory training.

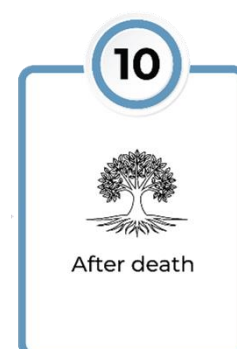


10. After death

A person's death from the administration of an approved voluntary assisted dying substance is considered an expected death. In this circumstance, an ambulance should not be called, and the person's death does not need to be reported to the police or coroner.

The person may stay at home for a period of time for friends and relatives to come and say their goodbyes. Some families like to bathe their loved one or conduct other ceremonies or rituals. It is recommended placing the person lying flat in a bed with their dentures in place (if applicable). The room should be kept cool.

The person's family or next of kin should liaise directly with their chosen funeral home to make arrangements to transfer the deceased person after their death.



10.1 Verification of death

The coordinating practitioner should have a plan to verify the person's death prior to the administration of the approved voluntary assisted dying substance.

Death is verified by clinical examination demonstrating the following:

- fixed and dilated pupils in reaction to light
- no palpable carotid pulse
- no heart sounds heard on auscultation for two minutes, and
- no breath sounds heard on auscultation for two minutes.

The following registered health practitioners can verify death:

- medical practitioners
- nurse practitioners, and
- registered nurses working in the VAD-CNS, palliative care, Hospital in the Home, or community nursing.

The health practitioner must complete the *Verification of death* form and document this in person's health record. The *Verification of death* form will go with the deceased person to the mortuary or funeral home.

10.2 Medical Certificate Cause of Death

Under the *Births, Deaths and Marriages Act 1997*, a medical practitioner who can form an opinion about the probable cause of death must complete a *Medical Certificate Cause of Death* (the certificate) within 48 hours of the death being verified, to notify the register general of the death.

The certificate can be completed by the coordinating or administering practitioner if they are a medical practitioner. If the coordinating or administering practitioner is not a medical practitioner, the certificate can be completed by another medical practitioner involved in the person's care, such as the person's general practitioner or another medical specialist.

Voluntary assisted dying must not be listed as the person's cause of death on the certificate. The cause of death must be listed as the relevant condition that made the person eligible to access voluntary assisted dying. The manner of death must be listed as administration of an approved voluntary assisted dying substance.

Following the completion of the certificate which notifies the register general, the register general will issue a death certificate to the family of the person to allow them to finalise the person's affairs. The death certificate will only list the relevant condition that made the person eligible to access voluntary assisted dying, and not the manner of their death.

10.3 Notification of death

10.3.1 Administrative tasks

Once the coordinating or administering practitioner becomes aware of the person's death from any cause, they must complete the *Notification of death* form in the online portal as soon as possible and within **4 business days**.

If the administering practitioner is not the person's coordinating practitioner, they must tell the coordinating practitioner about the person's death. The Board and the Director-General will be notified of the persons' death when the form has been submitted in the online portal.

If a person dies of any cause, the contact person must tell the coordinating practitioner about the death within **4 business days**, if a contact person appointment was in effect.

If the person dies after the administering practitioner administers the approved voluntary assisted dying substance to them, the administering practitioner must also prepare a *Practitioner administration certificate* and an *Administration witness certificate*. The certificates must be uploaded to the online portal within **4 business days**.

If the person dies before the administration of the approved voluntary assisted dying substance, the administering practitioner must submit a *Notification of death* form in the online portal to notify the Board.

If a medical practitioner is informed of a patient's death following administration of a voluntary assisted dying substance and they are asked to complete the Medical Cause of Death Certificate, but they are not an authorised practitioner, they must complete the *Notification of death – other* form located on the ACT Government website. This must occur within **4 business days** after the day the medical practitioner becomes aware of the person's death. This will automatically notify the Board and Director-General of the person's death.

10.4 Return and disposal of the approved voluntary assisted dying substance

There are specific requirements for the return and disposal of the approved voluntary assisted dying substance. This applies to the oral and intravenous substances and includes when the substance is unused or only partially used.

The approved voluntary assisted dying substance must be returned to the VAD-PS for disposal. No other hospital or community pharmacies are authorised to dispose of any voluntary assisted dying substances.

More information about the requirements for return and disposal are in the *ACT Voluntary Assisted Dying Prescription and Administration Manual*.

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Section 5: Voluntary assisted dying for diverse populations

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1. Culturally competent care

It is important to consider the cultural and spiritual considerations of each person and factor these into end-of-life care planning.

The principles of culturally competent care are:

- recognising there are as many differences within any culture as there are across cultures
- providing equitable access to healthcare services e.g. equal opportunity to access services, regardless of the person's location
- ensuring information is presented to the person in way they can understand and by a person they can trust
- supporting the person to make their own decisions based on their personal beliefs
- guiding shared decision making when appropriate
- ensuring that health professionals receive cultural capacity training as part of their ongoing professional development, and
- establishing trust by acknowledging and demonstrating understanding of the person's spiritual and cultural beliefs.

2. Aboriginal and Torres Strait Islander peoples

There are specific standards defined in the [Australian Commission on Safety and Quality in Health Care](#) that relate to the safety and quality of health care provision for Aboriginal and Torres Strait Islander peoples.

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice for health professionals involves ongoing clinical reflection of their own knowledge, skills, attitudes, behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

To support culturally safe and respectful practice, health professionals should:

- acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health
- acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism
- recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community, and
- foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

2.1 Providing culturally responsive end of life care to Aboriginal and Torres Strait Islander peoples

Elements to consider when providing culturally responsive end of life care to Aboriginal and Torres Strait Islander people include⁴:

- kinship systems often extend beyond immediate family members
- use of plain language, and awareness of the impact of non-verbal and verbal communication styles to influence your ability to establish therapeutic rapport
- recognising that Aboriginal and Torres Strait Islander peoples may have differing religious beliefs that may influence end of life care
- understanding that some Aboriginal and Torres Strait Islander people will wish to pass away on Country, and
- respecting the cultural significance of Sorry Business which may involve attending remote locations.

In line with cultural storytelling and beliefs, some Aboriginal and Torres Strait Islander peoples hold strong views about the cause of illness which can be at odds with Western medicine. There will be a greater likelihood to develop rapport and trust when these beliefs are acknowledged, valued and respected through meaningful and lasting action.

There is a common belief among many Aboriginal and Torres Strait Islander peoples that all living things have a spirit. Spirits may be what connect the past, present, and future. At the time of passing, some believe that the spirit leaves the body to return to the ancestor's Country. It may be the kinship unit's responsibility to ensure the safe passage of that spirit returning to the ancestor's Country. This may be achieved through ceremony, sorry business, and other cultural practices unique to each group.

Aboriginal and Torres Strait Islander communities are collectivist societies. This means that often the decision maker or family-spokesperson is not the individual person themselves that is registered for care as per the conventions of the Western Healthcare system. Decision making is often the family responsibility, not an individual one. It is imperative to seek an understanding of the dynamics in each family, and to ensure that the spokespeople or decision makers are present or properly consulted in all discussions. Ask specific questions such as "can you tell me the right person to talk about your health matters", or "are there any people that need to be included in the decision making about your personal and health information."

Aboriginal and Torres Strait Islander people may speak multiple languages with English being the second, third or even fourth language. Additionally, many Aboriginal and Torres Strait Islander communities don't have direct conversations about death and dying. Alternative terms are encouraged and should be directed by people you are caring for,

⁴ Australian Indigenous Health Info Net, [*Culturally appropriate palliative care and end-of-life care, 2024*](#), accessed online December 2024.

including using words such as “not going to get better, finishing up, sick person passed on, sad news, and sorry business”.

Some may choose not to discuss death and dying with health professionals, and some may request that these matters not be discussed with the ‘sick person’ themselves. Navigating these complex circumstances can be tricky, but ensuring a respectful, inquisitive, responsive and reflective approach, along with consulting the nominated decision makers and spokespeople will help to guide communication and engagement in a culturally sensitive way.⁴

Authorised practitioners should seek to achieve cultural safety throughout the voluntary assisted dying process while adhering to the *Voluntary Assisted Dying Act 2024* (the Act). Authorised practitioners can contact the VAD-CNS for guidance in complex clinical scenarios.



Recommended reading

- Providing end-of-life care for Aboriginal peoples and Torres Strait Islander people. Program of experience in the palliative approach
 - Aboriginal and Torres Strait Islander Patient Care Guidelines. Queensland Health. Published 2014.
 - Aboriginal and Torres Strait Islander Peoples Palliative Care Resources - Palliative Care Australia
 - Indigenous Program of Experience in the Palliative Approach (IPEPA)
 - Trudgen, R. (2004). *Why Warriors Lay Down and Die*. Djambatj Mala.
 - National Safety and Quality Health Service Standards (second edition) May 2021 https://www.safetyandquality.gov.au/sites/default/files/2021-05/national_safety_and_quality_health_service_nsqhs_standards_second_edition_-_updated_may_2021.pdf
 - Aboriginal and Torres Strait Islander Health Strategy Unit (HSU) <https://www.ahpra.gov.au/Health-Strategy-Unit.aspx>
 - Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020 – 2025 <https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx>
 - National Anti-Racism Framework <https://humanrights.gov.au/anti-racism-framework>
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3. Disability, mental disorder and mental illness

People with disability, mental disorder or mental illness, like others in the community, must meet all eligibility criteria to access voluntary assisted dying. For a person with a mental disorder or mental illness, this in isolation does not qualify as a relevant condition. A person with a disability will not have a relevant condition only because their disability results in the person needing to support them to live with their disability.

Authorised practitioners should:

- conduct assessments, without making assumptions about suffering or quality of life based on a person's disability status⁵
- ensure use of appropriate communication and decision-making supports for accessibility, and
- recognise that some people with disability may require additional support to communicate their needs and preferences. This may include assistive technologies, interpreters, or supported decision-making frameworks.⁶

This requires a commitment to inclusive decision-making, acknowledging systemic biases in healthcare and historical injustices that have affected the right of people with disability.⁷

3.1 Addressing medical ableism, diagnostic overshadowing and quality-of-life biases

The Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability identified systemic failings in Australia's healthcare system, including:

- barriers to informed medical decision-making
- neglect in end-of-life care, and
- discriminatory treatment.⁸

The Commission found that people with disability often experience medical ableism, less access to suitable healthcare, and assumptions that their lives have less value. These concerns are relevant for voluntary assisted dying, where equitable access to assessments, informed consent, and palliative care options must be ensured.

People with disability often experience diagnostic overshadowing. This is when health professionals mistakenly attribute symptoms to a disability rather than a separate

5 Australian Commission on Safety and Quality in Health Care. *Intellectual Disability and Inclusive Health Care*, 2024, accessed August 2025.

6 Australian Human Rights Commission, *Creating Accessible and Inclusive Communications*, 2024, accessed August 2025.

7 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report*, 2023, accessed August 2025.

medical condition. This can lead to misdiagnosis, underdiagnosis, or delayed care. To avoid this, authorised practitioners should:

- recognise and mitigate diagnostic overshadowing, ensuring that a person's symptoms from a terminal condition are not overlooked or misattributed to their disability⁸
- avoid making assumptions about a person's suffering or quality of life based on disability status
- ensure you listen to the person's own voice and perspective when making decisions, without any bias, and
- use affirming, non-stigmatising language that does not frame disability as a burden.⁹

3.2 Strengthening safeguards against coercion

The Royal Commission found that people with disability are at a higher risk of coercion due to:

- healthcare inequities
- financial pressures, and
- limited access to disability supports.¹⁰

These factors increase the risk of people with disability seeking voluntary assisted dying due to other pressures rather than personal choice. To avoid this, authorised practitioners should:

3.3 Accessible and inclusive communication

Many people with disability need support with communicating in medical settings.¹¹ Voluntary assisted dying assessments must be conducted in a way that ensures the person can fully understand and express their wishes¹².

8 Australian Commission on Safety and Quality in Health Care, *NSQHS Standards User Guide for the Health Care of People with Intellectual Disability*, 2024, accessed online August 2025.

9 J Graff and J Russell, Ableism in health care, *American Journal of Nursing*, 2023 123(2), 23-24, doi: [10.1097/01.NAJ.0000919712.93900.29](https://doi.org/10.1097/01.NAJ.0000919712.93900.29).

10 Australian Human Rights Commission, *Guidelines on the Rights of People with Disability in Health and Disability Care*, 2020, accessed online August 2025.

11 Australian Human Rights Commission, *Guidelines on the Rights of People with Disability in Health and Disability Care During COVID-19*, 2020, accessed online August 2025.

12 Australian Government Department of Health, *Management and Operational Plan for People with Disability – Appendix B: Communications Strategy*, 2020, accessed August 2025.

This can include:

- use of accessible formats, such as Easy English, large print, Braille, audio materials, and video resources with captions and Auslan interpretation¹³
- offer Augmentative and Alternative Communication (ACC) tools when needed, and
- ensure discussions occur with trusted support persons, when necessary, while maintaining the person's autonomy as central to the decision-making process.
- disability support person would be someone well known to the person. They would be familiar with their method of communication and would know the purpose of the consultation.¹⁵

3.4 Supported decision-making and capacity assessments

Some people with disability may require supported decision-making, which must not be confused with a lack of capacity.¹⁴ Authorised practitioners can achieve this by:

- recognising that needing support does not mean the person cannot make their own decisions¹⁵
- ensuring there is enough time for people to understand their decisions and consider their options¹⁶
- engaging independent supports or disability advocates to ensure fair and unbiased decision-making,¹⁷ and
- making sure the person's choice remains their own, rather than being made by family members or guardians.¹⁸

¹³ Speech Pathology Australia, *Augmentative and Alternative Communication (AAC)*, 2024, accessed online May 2025.

¹⁴ National Disability Insurance Scheme (NDIS). *Supported Decision-Making Policy*, 2023, accessed online August 2025.

¹⁵ NSW Department of Communities and Justice, *Capacity Toolkit*, 2022, accessed online August 2025.

¹⁶ Queensland Government, *Capacity Assessment Guidelines*, 2023, accessed online August 2025.

¹⁷ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final Report*, 2023, accessed August 2025.

¹⁸ Queensland Office of the Public Guardian, *Supported Decision-Making*, 2024. Accessed online August 2025.

3.5 Best practices for engaging with people with disability in discussions about voluntary assisted dying

Practitioners involved in voluntary assisted dying discussions must ensure that people with disability receive equitable, informed, and unbiased care.²⁰ This requires:

- asking open-ended questions to ensure the person fully understands and has control of their decisions¹⁹
- avoiding legal or medical language where possible and appropriate, which can be confusing or hard for the person to understand,²⁰ and
- consulting with disability advocacy organisations where needed to ensure the person has access to an inclusive process²¹.



Recommended reading

- Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability – Final Report:
<https://disability.royalcommission.gov.au/publications/final-report>
- UN Convention on the Rights of Persons with Disabilities (UNCRPD)
<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

4. Culturally and linguistically diverse communities

There are over 300 languages represented in the Australian community, and the cultural diversity within these groups can impact the experience of death and dying.²²

Language barriers, mistrust of the health system, and health literacy can often prevent timely access to high quality end of life care when needed. Health professionals can support people from culturally and linguistically diverse communities through the voluntary assisted dying process by making sure interpreting services and health information is available to them in their chosen language.

19 Australian Government Department of Social Services, *Australia's Disability Strategy 2021-2031*, 2024, Accessed online August 2025.

20 Australian Commission on Safety and Quality in Health Care. *Health literacy: taking action to improve safety and quality*, 2014. Accessed online August 2025.

21 Australian Commission on Safety and Quality in Health Care, *User Guide for the Health Care of People with Intellectual Disability*, 2024, Accessed online May 2025.

22 Palliative Care Australian Capital Territory, *Cultural Approaches to Death and Dying. A Toolkit for Carers*, accessed online May 2025.

The [Cultural Approaches to Death and Dying Toolkit](#) provides ACT specific information to assist health professionals to:

- recognise cultural differences
- understand the importance of cultural traditions during end of life care
- improve communication techniques
- be an advocate for the person receiving end of life care, and
- find resources to support the person receiving end-of-life care and their family.²⁵



Recommended reading

- Australian Government Department of Health (2019). [Exploratory Analysis of Barriers to Palliative Care - Issues Report on People from Culturally and Linguistically Diverse Backgrounds](#). Australian Healthcare Associates.
 - Clark, K. and Phillips, J. (2010). [End of life care – the importance of culture and ethnicity](#). *Australian Family Physician*. 39(4). PP: 210-213.
 - Lambert E, Strickland K, Gibson J. (2023). [Cultural considerations at end-of-life for people of culturally and linguistically diverse backgrounds: A critical interpretative synthesis - PubMed](#). *J Clin Nurs*. 2023 Apr 6. doi: 10.1111/jocn.16710
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Section 6: Other considerations

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1. Considerations for cross border residents

A person who lives in a place close to the ACT border and wants to access voluntary assisted dying in the ACT may apply for a residency exemption if they can demonstrate a substantial connection to the ACT. Where a residency exemption is granted, the ACT Government will provide written advice to the person. It is still a requirement that all steps of the process must occur in the ACT, including administration of the substance.

If a person who lives in the ACT wants to access voluntary assisted dying in NSW, they should contact NSW Voluntary Assisted Dying Care Navigation Service and apply for a residency exemption. It is possible that a person could be approved for voluntary assisted dying in NSW and ACT. However, they would have to follow separate approval processes under the different laws in NSW and ACT.

NSW Voluntary Assisted Dying Care Navigation Service

Phone: 1300 802 133 Monday to Friday, 8:30am to 4:30pm (excluding public holidays)

Email: NSLHD-VADCareNavigator@health.nsw.gov.au

2. Feedback and complaints

If a person has any feedback or concerns about their experience accessing voluntary assisted dying, they should be encouraged to raise these with:

- the relevant health professional, and
- manager of the service provider or agency.

Service providers should have a policy that outlines how they process consumer feedback and complaints. If a person has feedback or concerns about an interpreter's performance, support is available through the [National Accreditation Authority for Translators and Interpreters \(NAATI\)](#).

Concerns about a health professional not meeting requirements of the Act can be raised by contacting ACT Government.

Concerns about a health professional may be raised with the Australian Health Practitioner Regulation Agency (Ahpra) via 1300 419 495.

A full list of offences and penalties is in [Section 7: Appendices and resources](#).

2.1 The Health and Community Services Complaints Commissioner

Complaints about organisations that provide health, disability or mental health services can be made to the [ACT Health Services Commissioner \(the Commissioner\)](#). The Commissioner attempts to resolve health related complaints through conciliation with a health service or with a health practitioner.

2.2 Ombudsman ACT

Complaints about an ACT government agency can be directed to the ACT Ombudsman. Complaints will be assessed against criteria for investigation set by the Ombudsman, to determine whether an investigation is necessary or justifiable.

3. Reviewable decisions

ACT Civil and Administrative Tribunal (ACAT) is an independent body that makes and reviews a range of administrative, commercial, and personal matters in the ACT.

ACAT can review certain decisions under the Act, including decisions made by a coordinating or consulting practitioner about whether the person met the following eligibility criteria for voluntary assisted dying:

- if they have decision-making capacity in relation to voluntary assisted dying
- if their decision to access voluntary assisted dying is made voluntarily and without coercion, and
- if they have lived in the ACT for at least the previous 12 months

ACAT can also review decisions made by the Director-General, ACT Health and Community Services Directorate, in relation to:

- refusal to authorise a practitioner to be coordinating, consulting or administering practitioner
- revocation of a practitioner's authorisation because they are no longer eligible, and
- refusal to grant a residency exemption.

ACAT cannot review decisions about a person's medical condition related to their request to access voluntary assisted dying.

3.1 Applying for a review

An application to review a decision may be made by:

- the person accessing voluntary assisted dying
- another person who has a sufficient and genuine interest in the person's rights in relation to voluntary assisted dying.

3.2 During ACAT review

Within 2 days of receiving an application for review, ACAT will give a copy of the application to:

- the applicant and decision-maker
- if they were not the applicant, the person accessing voluntary assisted dying
- if they were not the decision maker, the coordinating practitioner

- if they were not the decision-maker, the consulting practitioner
- the Board, and
- any other person ACAT thinks is necessary.

Once an application has been made to ACAT to review a decision, the voluntary assisted dying request and assessment process is put on hold. No further steps may be taken until the matter is resolved or the application for review is withdrawn.

3.3 Timing and process

If the person wants ACAT to review a decision, they must submit an application as soon as possible. Depending on the reviewable decision they will have either 5 or 28 days to apply for a review. When a practitioner makes a reviewable decision, they must provide the person with a reviewable decision notice. This notice will advise the person how long they have to apply for review.

ACAT hearings about voluntary assisted dying must be held in private. ACAT has the power to keep the person's details anonymous in ACAT's publicly reported decisions. ACAT can take as long as needed to make its decision. If the person dies before they complete their review, the ACAT application does not continue and is treated as if it has been withdrawn.

3.4 Effect of a decision

ACAT may decide to support or overturn the decision made by an authorised practitioner. If the ACAT decision results in a change to a person's eligibility, the decision of the authorised practitioner is overturned, and the ACAT decision takes its place.

If the decision by the coordinating practitioner meant the person was not eligible and the ACAT decision means that the person is now eligible for voluntary assisted dying, the coordinating practitioner may refuse to continue in the role. If this happens, the coordinating practitioner must transfer the role to another practitioner so the person can continue the voluntary assisted dying process.

4. Health facilities

Health facilities, including private health and care facilities must have policies that reflect their obligations in relation to voluntary assisted dying. The policies must specify:

- if voluntary assisted dying services will be allowed to be conducted on their premises
- that care will not be withdrawn to a resident because they have asked for information about or access to voluntary assisted dying, and
- the facility operator will provide the contact details of the VAD-CNS upon request for information about voluntary assisted dying by a resident or their agent.

Policies must be published on the facility's website, and in formats that are likely to come to the attention of residents and potential residents, and accessible to residents and anyone who enquires. If a person asks for a facility's policies in relation to voluntary assisted dying, the facility must make the policy available to the person within 2 business

days. Concerns about a health facility not meeting requirements of the Act can be raised by contacting ACT Government.

4.1 Reasonable access to individuals who want access to voluntary assisted dying

For health facilities that do not provide their residents with services to facilitate access to voluntary assisted dying, there are obligations that those facilities must follow. The facility must allow reasonable access for people who can provide residents information about or access to voluntary assisted dying. This could include an authorised practitioner who needs access to the health facility to undertake a part of the voluntary assisted dying process or an employee of the ACT Voluntary Assisted Dying Care Navigator or Pharmacy Service.

4.2 Transferring people in health facilities that do not offer voluntary assisted dying on their premises

If the health facility does not allow a health practitioner reasonable access to the facility to provide a resident with information about or access to voluntary assisted dying, or the health practitioner is unable to attend the facility at an appropriate time, the facility must attempt to transfer the resident to another facility. The manager of the facility can contact the VAD-CNS to discuss possible transfer of the resident to a Canberra Health Services facility.

Careful consideration must occur when transferring a person from a facility to access voluntary assisted dying as it may impact the person physically, emotionally, or financially. For example, a person may be so unwell that the transfer process would be traumatic or painful, or the medicines required for transfer could affect the person's decision-making capacity and make them not eligible for voluntary assisted dying.

4.3 Determining whether transfer is reasonable

All decisions to transfer a person must be based on an appropriate clinical risk assessment by the person's coordinating practitioner. If the person does not have a coordinating practitioner under the Act, the person's treating doctor may complete the clinical risk assessment. Under the Act this role is referred to as the *deciding practitioner*.

When making decisions about transferring a person to access voluntary assisted dying services, the deciding practitioner must have regard to the following matters:

- the person's wishes and preferences
- if the transfer is likely to cause serious harm to the person or there is a high risk of dying in transit
- if the transfer is likely to adversely affect the person's access to voluntary assisted dying

- if the transfer is likely to cause undue delay and prolonged suffering to enable access to voluntary assisted dying
- if the place that that person is proposed to be transferred to is available to receive the person and meet the person's needs, and
- if the person may incur a financial loss or cost because of the transfer.

It is good clinical practice for the deciding practitioner or the facility to consult with the person's treating team and other relevant practitioners involved in the person's care (for example, general practitioner, palliative care, physiotherapy) to discuss how the transfer may affect the person. With the person's consent, the deciding practitioner or the facility may also wish to include the person's family or carer in this process if appropriate.

If the deciding practitioner determines that the transfer is reasonable and the person consents, the facility must, as soon as practicable, facilitate the transfer of the individual.

If the deciding practitioner determines that the transfer is unreasonable due to risk of harm to the person or clinical instability, alternative care arrangements such as urgent referral to Specialist Palliative Care or acute care options should be discussed.

4.4 Transfer arrangements

There are a variety of settings in which a person may access voluntary assisted dying. A person may need a transfer to attend an outpatient consultation or to be admitted to another facility for some, or all, of the voluntary assisted dying process. Settings might include a private care facility that participates in voluntary assisted dying, hospice, a public hospital, private consulting rooms, or a family member's private residence. Contact the VAD-CNS to discuss possible transfer to a Canberra Health Services facility.

If a transfer is deemed reasonable, usual organisational policies and procedures relating to patient/resident transfer and clinical handover should be followed. It should be made clear to the accepting facility that the purpose of the transfer is for provision of voluntary assisted dying services. Appropriate escorts should be arranged by the transferring facility as clinically indicated.

If the person needs to leave the health facility to access voluntary assisted dying assessments, the transferring facility is required to receive the person back following this. Exceptions exist when the person is transferred for administration of the voluntary assisted dying substance, or where the person has chosen to receive care elsewhere or be discharged.

More information for health facilities is available on the ACT Government website.

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Section 7: Appendices and resources

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1. Authorised practitioner toolkit

Table 1: Prognostication tools

Resource	Overview
The Gold Standards Framework (GSF) Proactive Identification Guidance (PIG)	The GSF Proactive Identification Guidance (PIG), is a practical guide for clinicians enabling early recognition of end of life. It is used to support assessment and planning of care in line with their needs and wishes.
Support and Palliative Care Indicators Tool (SPICT)	SPICT™ is used to identify clinical signs of serious illness. SPICT™ helps clinicians to identify changes in health and wellbeing and increasing care needs. This can assist clinicians to determine if the person should be offered a palliative care services and prompts for end of life discussions.
Palliative Prognostic Index (PPI)	The PPI is used to determine a person's estimated time of survival based on oral intake, oedema, dyspnoea and delirium. This focus of this index is the terminal phase of illness.
Palliative Prognostic Score (PaP)	The Palliative Prognostic Score (PaP) is a validated prognostication tool that generates a score. The score attempts to indicate likely 30-day survival probability.

Table 2: Resources to support end of life planning

Resource	Overview
Advance care planning, ACT Government	Advance care planning documents, contact details and information about the ACT Advance Care Planning Team, and printable person information. • Advance care planning in the ACT booklet (PDF 1MB) • Advance care planning infographic (PDF 240KB)
End of Life Law for Clinicians (ELLC)	Provides accurate and practical information to assist navigating the challenging legal issues that can arise with end of life decision-making. This website features learning modules for all health practitioners involved in end-of-life care.
Palliative care services, ACT Government	Information about palliative care services available in the ACT, including clinical and non-clinical

	services, community service providers, private service providers and Canberra Health Services specialist palliative care services.
<u>Palliative Care ACT</u>	Community based organisation focused on promoting and advocating for palliative care services in the ACT.
<u>Palliative Care Australia</u>	Resources to help people, their friends, families and carers to understand what palliative care is, who it is for and where is it provided. Multilingual resources also available.
<u>National Palliative Care Standards for all Health Professionals and Aged Care Services, Palliative Care Australia</u>	These Standards have been developed with the aim of supporting better outcomes for people receiving palliative care.
<u>End of Life Directions for Aged Care (ELDAC)</u>	Information, guidance and resources for staff working in aged care to support palliative care and advance care planning. The ELDAC Care Model promotes holistic and person-centred care for older people with palliative care needs in the last months and days of life.

Table 3: Clinical resources

Resource	Overview
<u>CareSearch clinical evidence summaries</u>	Evidence-based information to improve areas of clinical practice including stages of care, common symptoms and palliative care emergencies.
<u>Clinical practice guidelines for communicating prognosis and end of life issues with adults in the advanced stages of a life-limiting illness, and their caregivers</u>	These guidelines help clinicians to have end of life discussions with people who have progressive, life-limiting illnesses.
<u>Clinical Principles for End of Life and Palliative Care, NSW Government</u>	Identifies the clinical principles that underpin the delivery of high quality and accessible end of life and palliative care for people in NSW.

<u>National Consensus Statement: Essential elements for safe and high-quality end of life care</u> , Australian Commission on Safety and Quality in Health Care	This Statement lists the essential elements for delivering safe and high quality end of life care in Australia. Elements 1–5 describe how end of life care should be approached and elements 6–10 describe the organisational processes required for safe and high quality end of life care.
<u>Prognostic tools in persons with advanced cancer: a systematic review</u>	This review examines prognostic tools for people with advanced cancer.
<u>Prognostic models and factors identifying end of life in non-cancer chronic diseases: a systematic review</u>	This systematic review examines the accuracy of prognostic models and highlights the need for robust, validated models.
<u>Victoria's end of life and palliative care framework</u> , Victorian Department of Health	This framework describes a person-centred approach for delivering person-centred care.
<u>How accurate is the 'surprise question' at identifying persons at the end of life? A systematic review and meta-analysis</u>	The 'Surprise Question' ("Would you be surprised if this person died within the next x months") is a screening tool that aims to identify people nearing the end of life.
<u>Palliative care outcomes collaboration clinical manual</u>	Aims to provide palliative care clinicians with assessment tools and data that can be used in clinical practice.
<u>End of life and palliative care: essential components</u> , NSW Government	Tools to assist clinicians to recognise end of life.
<u>Coercive Control Resources</u> , Justice and Community Safety Directorate, ACT Government.	ACT Government resources on identifying and responding to potential instances of coercive control.
<u>Coercive Control Resources</u> , Attorney-General's Department, Australian Government	General coercive control information including videos and other resources.
<u>How Coercive Control Affects People with Disability</u> , Attorney-General's Department, Australian Government	A range of resources around coercive control and its impacts on people living with disability.

2. List of required forms

Form	Form submitted or completed by	Timeframe for submission to the Board on the online portal
<i>First assessment report</i>	Coordinating practitioner	Within 4 business days of decision being made
<i>Accept or refuse consulting assessment referral</i>	Health practitioner who received the referral	Within 4 business days of telling the coordinating practitioner about the decision
<i>Consulting assessment report</i>	Consulting practitioner	Within 4 business days after decision made in consulting assessment
<i>Second request</i>	Completed by person and 2 independent witnesses-submitted by coordinating practitioner	Within 4 business days of receiving a completed second request.
<i>Notification of second request</i>	Coordinating practitioner	Within 4 business days of receiving a completed second request.
<i>Final request</i>	Coordinating practitioner	Within 4 business days after receiving the final request
<i>Final assessment report</i>	Coordinating practitioner	Within 4 business days after final assessment decision is made
<i>Further final assessment report</i>	Coordinating practitioner-to occur when a prescription requires re-issue	Within 4 business days after the further final assessment decision is made
<i>Administration decision</i>	Coordinating practitioner	Within 4 business days of being informed of the decision
<i>Change an administration decision</i>	Coordinating practitioner	Within 4 business days of being informed of the decision

<i>Revoking an administration decision</i>	Coordinating practitioner or administering practitioner	Within 4 business days of being informed of the decision
<i>Record of transfer of substance by administering practitioner</i>	Administering practitioner	Within 4 business days of the day the person transfers possession of the voluntary assisted dying substance to the administering practitioner
<i>Transfer of practitioner</i>	If the transfer was initiated by the practitioner - Original coordinating or administering practitioner If the transfer was initiated by the person – New coordinating or administering practitioner	Within 4 business days of the person being informed of the acceptance of the transfer request by the new practitioner
<i>Contact person appointment</i>	Completed by person – submitted by coordinating practitioner	Within 4 business days of receiving the appointment form
<i>Ending appointment of a contact person</i>	Coordinating practitioner	Within 4 business days of being informed of ending of the appointment
<i>Appointment of administering practitioner</i>	Administering practitioner	Within 4 business days of agreeing to act as the administering practitioner
<i>Written notice of prescription</i>	Coordinating Practitioner	Within 4 business days of the prescription
<i>Practitioner administration certificate</i>	Administering practitioner	Within 4 business days of the substance being administered
<i>Administration witness certificate</i>	Completed by witness	At time of administration
<i>Notification of administration witness certificate</i>	Administering practitioner	Within 4 business days of the substance being administered
<i>Notification of death</i>	Administering or coordinating practitioner	Within 4 business days after administration, or

		from becoming aware about death
<i>Notification of death – other</i>	Medical practitioner who is not an authorised voluntary assisted dying practitioner	Within 4 business days after the day the medical practitioner becomes aware of the person's death

3. List of penalties and offences

Penalty units (PUs) are used to define the amount payable for fines for committing an offence and each PU represents a certain monetary amount. At the time of writing, 1 PU equals \$160 for an individual or \$810 for a corporation in the ACT.

Section of Act	Role	Offence	Timeframe	Penalty (PU= penalty units)	Strict liability
18	Coordinating practitioner	Failure to give the board a copy of the first assessment report	Within 4 business days of decision being made	20PU	Yes
22	Health practitioner	Failure to notify board about decision to accept or refuse referral for consulting assessment	Within 4 business days of coordinating practitioner being informed	20PU	Yes
25	Consulting practitioner	Failure to give the board a copy of the consulting assessment report	Within 4 business days after decision made in consulting assessment	20PU	Yes
30	Coordinating practitioner	Failure to provide board copy of the second request	Within 4 business days of receipt of second request	20PU	Yes
34	Coordinating practitioner	Failure to notify board of receiving the final request	Within 4 business days after receiving the final request	20PU	Yes

36	Coordinating practitioner	Failure to provide a copy of the final assessment report to the board	Within 4 business days after final assessment decision is made	20PU	Yes
37	Coordinating practitioner (original)	Failure to notify board of transfer of coordinating practitioner functions	Within 4 business days after being told the request had been accepted	20PU	Yes
38	New coordinating practitioner	Failure to notify board about acceptance of transfer of coordinating practitioner functions	Within 4 business days after accepting the request	20PU	Yes
40	A person	Inducing, dishonestly or by coercion, an individual into making a request for access to voluntary assisted dying	Nil	7 years imprisonment	No
40	A person	Inducing, dishonestly or by coercion, an individual into revoking a request for access to voluntary assisted dying	Nil	100PU	No
42	Coordinating practitioner	Failure to notify board of making an administration decision	Within 4 business days of being informed of the decision	20PU	Yes
43	Coordinating practitioner	Failure to provide the board with written notice of the changing of administration decision	Within 4 business days of being informed of the change of the decision	20PU	Yes

44	Administering practitioner	Failure to provide written notice to board of agreement to act as administering practitioner.	Within 4 business days after informing the individual of the decision	20PU	Yes
45	Coordinating practitioner or Administering practitioner	Failure to provide written notice to board of revocation of administration decision	Within 4 business days of being informed of the revocation	20PU	Yes
46	Administering practitioner (original)	Failure to notify board about the acceptance of the transfer request	Within 4 business days of the individual being informed of the acceptance of the request	20PU	Yes
47	Administering practitioner (new)	Failure to notify board about the acceptance of the transfer request	Within 4 business days of the individual and original administering practitioner being informed of the acceptance of the request	20PU	Yes
49	Any person	Inducing an individual, dishonestly or by coercion, into making an administration decision	Nil	7 years imprisonment	No
49	Any person	Inducing an individual, dishonestly or by coercion, into revoking an administration decision	Nil	100PU	No

51	Coordinating practitioner	Failure to notify board of appointment of contact person	Within 4 business days after receiving contact person appointment	20PU	Yes
53	Coordinating practitioner	Failure to give notice to the board of the ending of a contact person appointment.	Within 4 business days of being informed.	20PU	Yes
58	Coordinating practitioner	Failure to give notice to the board that a prescription has been issued.	Within 4 business days of the prescription	20PU	Yes
59	Coordinating practitioner	Failure to give notice to the board that a subsequent prescription has been issued.	Within 4 business days of the prescription	20PU	Yes
60	Approved supplier	Supplying a substance to a person not to them personally or through a prescribed courier	Nil	20PU	No
60	Courier	Failure to comply with the regulations concerning receiving, possessing or delivering the substance	Nil	20PU	No
60	Approved supplier	Failing to provide a copy of the supply record to the board	Within 4 business days after supplying the substance	20PU	Yes
61	Contact person	Failing to inform the board that they had given the	Within 4 business days after the contact person gives an	20PU	Yes

		substance to the individual	approved substance to the individual		
62	Administering practitioner	Failing to inform the board that they had received the substance from the individual	Within 4 business days after the individual gives an approved substance to the administering practitioner	20PU	Yes
65	Administering practitioner (old)	Failure to comply with a request to give the new Administering practitioner the substance	Within 2 days after the new administering practitioner requests the substance	100PU	No
65	Administering practitioner (old)	Failure to inform the board that they have provided the substance to the new Administering practitioner	Within 4 business days of transferring the substance	20PU	Yes
67	Contact person (old)	Failure to comply with a request to give the person or the new Contact person the substance	Within 2 days after the person requests the substance be transferred	100PU	No
67	Contact person (old)	Failure to inform the board that they have provided the substance to the new Contact person	Within 4 business days of transferring the substance	20PU	Yes
68	Individual or Contact Person	Failure to give the approved substance to an approved disposer after a revocation	Within 14 days after the revocation of the self-	100PU	No

		of a self-administration decision	administration decision		
69	Contact Person	Failure to give remaining substance to an approved disposer after their contact appointment ends or the death of the individual	Within 14 days after no longer being a contact person or the person's death	100PU	No
72	Individual or other person	Failing to give an expired substance to an approved disposer	Within 14 days of being aware of the expiry of the substance	100PU	No
73	An approved disposer	Failing to notify the board of receipt of the substance	Within 4 days of receiving the substance	20PU	Yes
73	An approved disposer	Failing to provide the board a copy of the disposal record	Within 7 days after disposal	20PU	Yes
74	A person	Failing to follow prescribed storage requirements	Nil	20PU	No
75	A person	Administering an approved substance to a person if they are not authorised to do	Nil	7 years	No
76	A person	Inducing an individual, dishonestly or by coercion, into self-administering an approved substance	Nil	7 years	No

79	Coordinating practitioner	Failing to notify the board of a person's death	Within 4 business days after becoming aware of the person's death	20PU	Yes
80	Administering practitioner	Failing to notify the board of a person's death	Within 4 business days after becoming aware of the person's death	20PU	Yes
81	Administering practitioner	Failing to provide the board a copy of the administration and witness certificates	Within 4 business days after administration	20PU	Yes
83	Health practitioner under section 82 who is required to give notice of death and cause of death under the <i>Births, Deaths and Marriage Act</i>	Failing to provide the board notice of the death	Within 4 business days of becoming aware of the person's death	20PU	Yes
84	A coordinating practitioner or contact person	Failing to provide more information about the death upon a request by the board	Within the time specified in the request	20PU	Yes
98	A person	Acting as a coordinating practitioner, consulting practitioner or administering practitioner without authorisation or with a personal	Nil	100 PU, imprisonment for 12 months or both	No

		interest in the individual			
100	A health practitioner or health service provider prescribed by regulations (social worker or speech pathologist)	Failing to provide the contact details to the care navigator service after a conscientious objection	Within 2 business days of conscientious objection	20PU	Yes
104	A facility operator	Denying reasonable access to allow a relevant person who will provide information or access to voluntary assisted dying to a person who has requested it	Nil	100 PU	No
105	A facility operator	Failing to transfer an individual to a facility that will allow them access to voluntary assisted dying if the practitioner decides that the transfer would be reasonable and the individual consents to the transfer	As soon as reasonably practicable	100PU	No
105	A facility operator	Failing to give notice to the board stating the reasons that a transfer did not happen and the	Nil	20PU	Yes

		steps taken by the facility to enable a transfer			
106	A facility operator	Failure to take reasonable steps to allow a relevant person to have access at the facility to an individual seeking voluntary assisted dying	Nil	100PU	No
107	A facility operator	Failing to provide the contact details of care navigator to an individual who requesting information about voluntary assisted dying	2 business days after the request is made	30 PU	Yes
107	A facility operator	Failing to grant reasonable access to an official of the Care Navigator Service to an individual who requested voluntary assisted dying at the facility	Nil	100 PU	No
108	A facility operator	Failing to have a voluntary assisted dying policy (compliant with div 7.2)	Nil	20PU	Yes
108	A facility operator	Failing to publish voluntary assisted dying policy	Nil	20PU	Yes

108	A facility operator	Failing to make the voluntary assisted dying policy available to an individual who requests for it	2 business days after the request	20PU	Yes
109	A facility operator	Withdrawing care service from an individual due to knowledge of request or interest in voluntary assisted dying	Nil	100PU	No
143	A person	Contravening a non-publication order made by ACAT	Nil	50PU or imprisonment for 6 months or both	No
149	Coordinating practitioner	Failing to provide a copy of an ACAT decision to the board	3 business days after receiving a copy of the final order	20PU	Yes
160	A person	Recklessly using protected information about someone else	Nil	50PU or imprisonment for 6 months or both	No
160	A person	Recklessly communicating, publishing or leading to the communication or publishing of protected information about someone else	Nil	50PU or imprisonment for 6 months or both	No

