

EUTHANASIA

Motion

HON NICK GOIRAN (South Metropolitan) [11.37 am] — without notice: I move —

That this house—

- (a) noting that —
 - (i) the Belgium Parliament has recently authorised the direct killing of children through euthanasia;
 - (ii) euthanasia or assisted suicide is now routinely performed in Belgium and the Netherlands on persons with no terminal illness but with psychiatric disorders such as anorexia or depression or with disabilities such as blindness; and
 - (iii) Dr Philip Nitschke, during a recent visit to Perth, offered instruction in methods of suicide including how to illegally obtain pentobarbitone, a schedule 8 poison, and how to use nitrogen as an undetectable means of ending life;
- (b) condemns the practice of child euthanasia;
- (c) commends palliative care as an appropriate response to terminal and chronic illness;
- (d) affirms the value of every human life including those with mental illness or disability; and
- (e) endorses suicide prevention as the appropriate response to all those who for whatever reason may think life is not worth living.

When I last spoke on the issue of euthanasia and assisted suicide in my contribution to the budget debate on 17 October last year, there was so much compelling evidence from Oregon on the dangers involved that there was insufficient time for me to address the situation elsewhere around the globe. On that day, the Tasmanian House of Assembly rejected the Voluntary Assisted Dying Bill 2013, dismissing the claim by proponents that legalised euthanasia was working well in Oregon, the Netherlands and Belgium as unfounded. Sadly, since then Belgium has legalised the killing of children by euthanasia, and Dr Philip Nitschke has brought his travelling circus to Perth, touting his latest deadly toy—the nitrogen cylinder.

I turn to the issue of Belgium, where deaths by euthanasia have increased sixfold since it was legalised in 2003, from 235, to 1 432 in 2012. In Flanders in 2007, nearly one-third of deaths by euthanasia were brought about without any explicit request from the patient. Although the law only authorises doctors to perform euthanasia, nurses administered the legal drugs in 12 per cent of cases involving an explicit request, and in 45 per cent of cases without an explicit request. Belgium allows organ donation after euthanasia, including from people with psychiatric disorders, such as a woman suffering from automutilation, which is cutting to cause self-harm. Her consent was accepted as valid, despite her mental illness. Tom Mortier, whose mother was euthanased in April 2012 for chronic depression, wrote in an article on 4 February last year that —

I was not involved in the decision-making process and the doctor who gave her the injection never contacted me.

...

How is it possible that people can be euthanased in Belgium without close family or friends being contacted? Why does my country give medical doctors the exclusive power to decide over life and death? How do we judge what “unbearable suffering” is? ... Can we rely on such a judgment for a mentally ill person?

After all, can a mentally ill person make a “free choice”? ... How can a medical doctor be “absolutely certain” that his/her patient doesn’t want to live anymore?

In December 2012, deaf identical twin brothers asked to be euthanased after being distressed at learning they were going blind. Dr Marc Maurer, president of the US National Federation of the Blind, said —

“This disturbing news from Belgium is a stark example of the common, and in this case tragic, misunderstanding of disability and its consequences.

[Quorum formed.]

Hon NICK GOIRAN: I was quoting Dr Marc Maurer, president of the US National Federation of the Blind, who said —

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“This disturbing news from Belgium is a stark example of the common, and in this case tragic, misunderstanding of disability and its consequences. Adjustment to any disability is difficult, and deaf-blind people face their own particular challenges, but from at least the time of Helen Keller it has been known that these challenges can be met, and the technology and services available today have vastly improved prospects for the deaf-blind and others with disabilities. That these men wanted to die is tragic; that the state sanctioned and aided their suicide is frightening.”

In late 2012, 44-year-old Ann G requested to be euthanased because of her unbearable psychological suffering. She had been treated for anorexia since her teenage years by psychiatrist Walter Vandereycken. In 2008 she accused him of sexually abusing her under the guise of therapy. In October 2012, Vandereycken admitted to sexually abusing his patients. Following this, Ann G spoke of temporary relief from “the cancer in her head”, but subsequently persisted in her request for euthanasia. Sadly, she will not be able to testify against her abuser if charges are laid.

In September 2013, Nathan Verhelst requested to be euthanased because of his unhappiness following a sex change operation. Nathan, who was born Nancy, had been rejected by a family who hated girls. Verhelst’s mother was quoted in the United Kingdom’s *The Telegraph* at the time as saying —

“When I saw ‘Nancy’ for the first time, my dream was shattered. She was so ugly. I had a phantom birth. Her death does not bother me.”

Dr Wim Distelmans, who euthanased Verhelst, is co-chairman of the Belgium Euthanasia Control and Evaluation Commission, which examines all reported cases of euthanasia but has never reported a single case to the police for investigation. Distelmans has commented on how the commission handled the case. He said —

... we didn’t discuss about the case for one minute. It was just passed like that,” ... “We already have a tradition of 10 years. Should Nathan’s case have been 10 years ago, maybe we would have discussed some time about the case. Now, it’s like [just] another one.”

When there is not a terminal illness or specific psychiatric disorder, the reason for euthanasia is given as “poly pathology”, which simply means that the sum of ailments and limitations is held to be unbearable. Last month it became legal in Belgium for emancipated minors to request euthanasia on the same terms as adults, including on mental health grounds, and for other children with the capacity for discernment to request euthanasia for a hopeless medical situation likely to result in death. For unemancipated minors, one parent must consent.

I turn now to the situation in the Netherlands. Euthanasia was legalised in the Netherlands in 2003. The number of deaths there has more than doubled from 1 815 in 2003 to 4 188 deaths in 2012. Euthanasia now accounts for nearly three per cent of all deaths in the Netherlands. Euthanasia is routinely carried out for dementia, depression and other mental health issues. In 2012, there were 42 notifications involving patients with dementia, and 14 involving patients with psychiatric problems. The Royal Dutch Medical Association states that as the elderly experience —

... various other ailments and complications such as disorders affecting vision, hearing and mobility, falls, confinement to bed, fatigue, exhaustion and loss of fitness take hold, ... The patient perceives the suffering as interminable, his existence as meaningless and—though not directly in danger of dying from these complaints—neither wishes to experience them nor, insofar as his history and own values permit, to derive meaning from them.

... such cases are sufficiently linked to the medical domain to permit a physician to act within the confines of the Euthanasia Law.

In 2013, a woman asked to be killed by euthanasia because of her blindness. She was distressed at not being able to see whether her clothes were stained or to see new clothes when shopping. She refused a guide dog on the grounds that she wanted to walk a dog, not be led by one.

Case 15 of the “Dutch Regional Euthanasia Review Committees: 2011 Annual Report” concluded that the attending physician failed to accurately diagnose a woman’s back pain and prescribed only limited pain-relief medication. Consequently, it could not be said that the woman’s pain was definitively unrelievable. This woman has now been euthanased and can get no relief from this finding of error.

What has been the response to this around the globe? I will start with the Council of Europe, the Parliamentary Assembly of which, in response to the out-of-control situation in Belgium and the Netherlands, resolved 41 to nine on 25 January 2012 —

Euthanasia, in the sense of the intentional killing by act or omission of a dependent human being for his or her alleged benefit, must always be prohibited.

In April 2013, The World Medical Association in April 2013 noted that —

... the practice of active euthanasia with physician assistance, has been adopted into law in some countries.

...

The World Medical Association reaffirms its strong belief that euthanasia is in conflict with basic ethical principles of medical practice, and The World Medical Association strongly encourages ... physicians to refrain from participating in euthanasia, even if national law allows it or decriminalizes it under certain conditions.

I turn now to the situation with the Australian and New Zealand Society for Palliative Medicine, which endorsed the World Medical Association's position in October 2013. Its position statement on this issue reads, in part —

The discipline of Palliative Medicine does not include the practice of euthanasia or assisted suicide;

...

ANZSPM opposes the legalisation of both euthanasia and assisted suicide.

The World Health Organization's definition of palliative care, which has been adopted by Palliative Care Australia, specifies on page 8 of its 2008 "Glossary of Terms" that palliative care —

intends neither to hasten or postpone death;

It also states —

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

I am pleased to say that, along with my co-convenor of the Parliamentary Friends of Palliative Care, Margaret Quirk, MLA, at 1.00 pm today in the Aboriginal People's Room I will host a briefing for members provided by Dr Yvonne Luxton, CEO of Palliative Care Australia, titled "National and International Developments in Palliative Care: Implications for Western Australians, including Aboriginal people". Meanwhile, this coming Monday Dr Patsy Yates, president of Palliative Care Australia, will present the new position statement on paediatric palliative care which, in sharp contrast to the Belgian approach of offering to kill children who are terminally ill, states on page 3 that it —

... aims to provide the best quality of life through an holistic approach which supports the physical, emotional, social and spiritual aspects of the child and their family. "The goal is to add life to the child's years, not simply years to the child's life."

...

Children and adolescents need to experience the best life possible regardless of their prognosis, and *especially* if their time is limited.

I will now briefly turn to the issue of elder abuse and people at the other end of life. Just last week the Minister for Seniors and Volunteering, Hon Tony Simpson, MLA, announced funding for an elder abuse hotline to assist the 12 500 seniors who are exploited or abused in Western Australia each year, mainly by their own children, partners and family carers. Financial abuse is the most common form of elder abuse, but emotional, social, physical and sexual abuse can also occur. Elderly people would be put at further serious risk of abuse by a law permitting euthanasia or assisted suicide, which could allow others to subtly coerce them into agreeing to die to free up an inheritance or to rid others of a burden of care.

I conclude by asking: suicide promotion or suicide prevention? In a 2001 interview, when asked who should be given help to kill themselves, Dr Philip Nitschke answered that someone needed to provide this knowledge, training or the recourse necessary to anyone who wanted it, including the depressed, the elderly bereaved or the troubled teen. He said that if we are to remain consistent and we believe that the individual has the right to dispose of their life, we should not erect artificial barriers in the way of sub-groups who do not meet our criteria.

During his visit to Perth on 24 February 2014, Nitschke gave Western Australians detailed instruction in methods of killing, including how to illegally obtain the schedule 8 poison pentobarbitone and how to use

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nitrogen as an undetectable means of bringing about death. I am mindful of the prolonged and tragic death of Western Australian mother Erin Berg who, while suffering from postnatal depression, followed Nitschke's detailed instruction manual and travelled to Mexico to purchase and self-administer that drug, dying 12 days later in a Mexican hospital. Nitschke dismisses the deaths of those with mental illness who follow his detailed suicide instructions as mere collateral damage. He said that while young people and those with mental illnesses could access Exit's instructions on the internet, the risks of this had to be weighed against the benefits for many others. He said that there will be some casualties, but that this had to be balanced with the growing pool of older people who feel immense wellbeing from having access to this information.

This is a cult of suicide and death that I want no part of. In response to the challenges of suffering and despair there is always a better way than killing.

HON SUE ELLERY (South Metropolitan — Leader of the Opposition) [11.55 am]: Members will be aware that for members of our party, this is a conscience vote. I do not support euthanasia for children, but I do support the principle of voluntary euthanasia for adults. I have previously, and will again, supported legislation that gives effect to voluntary euthanasia for adults in situations in which I believe that the legislation contains the appropriate safeguards. I am a member of the Western Australian Voluntary Euthanasia Society, so some people might think that I would automatically vote against a motion like this, or that I would automatically support every bit of legislation that comes before this place that deals with euthanasia, but I will not; I will exercise my right to make a judgement on each and every issue.

I would probably not accept some of the premises of part (ii) of the motion before us, and if this were the kind of motion that went to a vote I might seek to amend it and, if that were not successful, I might vote against it, but it is not going to a vote. My position is unequivocal: I do not support euthanasia for children, but I do want to make some comments on euthanasia in general. As I have said in previous debate on this matter, I am guided most usefully by the views, comments and advice that I personally received from Marshall Perron, former Chief Minister of the Northern Territory. I met with him when there was a private member's bill before this place and found his advice and counsel really useful.

I am guided by a strong ethical framework, which is why I qualified my remarks by saying that my judgement on any legislation or anything to do with this matter is not an automatic decision but one that would be qualified by the details I was being asked to consider. Essentially, the ethical framework that I apply to questions of voluntary euthanasia is about autonomy and self-determination. I want to be able to make a rational choice for myself and to have all the options available to me. I think it is right and proper that the state does not stand in my way, but it is also right and proper for the state to ensure that I have not been coerced and that there is a framework of rights and obligations to protect me, my loved ones and the medical practitioners involved. Right now in Western Australian hospitals and nursing homes, as is the case across the rest of Australia and in most parts of the world, medical practitioners are daily making decisions about issuing dosages of morphine and other drugs of that ilk to patients in the name of pain control, in the knowledge that there could be a double effect. I witnessed that situation with my own grandmother, and there was absolutely no question that it was the right thing to do. I might add that it was done in a Catholic hospital. There are some who would argue that the medical practitioner knew that a very likely effect of increasing the dosage of morphine would be that she would pass away within a short space of time. The medical practitioner explained that to us, and that is exactly what happened.

There are questions that still remain in this state about the legal framework protecting that medical practitioner, and I think those questions need to be resolved. That is why I would be supportive of legislation that does that. I am equally of the view that there needs to be very good, well-resourced and widely accessible palliative care; the two are not mutually exclusive. We need good palliative care, and we do not have enough of it. We should have more of it, and it needs to be much more widely accessible than it is. I have personally witnessed the fantastic work that is done at the hospice run by St John of God Murdoch; it is absolutely fabulous, and there should be more services like that. However, palliative care is not the solution for everybody and it is certainly not accessible to everybody, but equally we should not promise people that palliative care will give them everything they need because for some people that just will not be the case.

I want to say this as well, and then I will stop because other people want to make a contribution to this motion: Marshall Perron makes the point that we are living longer and dying more slowly. Medical, technological and drug advances mean that we are living way beyond the age we used to live to, and that the ability to keep us alive once we are diagnosed with a condition is such that it is taking us a lot longer to die than it ever used to. We as a community need to address the questions that those advances raise for us. If I can be as bold as to put members of this chamber in one generation—which is not accurate, but I will be that bold: as consumers of health care and other things, we are much more assertive than previous generations used to be. I do not think that this generation of people sitting in this place now will accept the kinds of restraints and the poor level of service that

are available, for example, to our parents right now and that were available to them in the past. This issue will not go away because of that. I think it is an issue that we will be required to constantly think about.

I want to be able to make a decision that is the right one for me. That decision for me may well be that I will fight to stay alive with the very last breath in my body. Equally, it may well be that I will make a decision that the quality of life is not of a quality that I want, and that if my life is going to end anyway because of whatever condition I have, I might want to end it before the drugs would otherwise let me. It is the case as well, of course, that we are living now with degenerative diseases much more than we ever did before, and that for some the quality of life that goes with that is diminished beyond the reasonable quality that people want to live with. I will continue to hold the view in principle of supporting voluntary euthanasia. I will apply, however, a strong framework to every proposition that comes before me so that I will make a judgement absolutely on the detail of what is before me. I cannot, do not and will not support euthanasia for children. I remain supportive of voluntary euthanasia for adults when appropriate safeguards are in place.

HON LIZ BEHJAT (North Metropolitan) [12.02 pm]: Today I rise to support my colleague in this motion that he has brought to the house. However, as always, and as we have come to expect from the work that Hon Nick Goiran presents to us, there is so much in this motion that we could all speak for 45 minutes were it a motion on the notice paper rather than a motion moved in private members' business. However, I will make my contribution to it.

I do not support euthanasia. I definitely do not support euthanasia for children. I especially find abhorrent the thought that euthanasia should be available for people with an illness or a mental disorder. I am a very strong supporter of a good palliative care regime. Before I continue with my contribution, I want to go on the record to say that I think there is a belief among people that someone has to be some sort of religious nutter to be opposed to euthanasia and that it is only those who hold particular religious beliefs that share my abhorrence of euthanasia. I firmly put it on the record that I do not practise any particular religion and I do not have any particular strong religious beliefs, but I do hold true to very, very strong beliefs against euthanasia.

Palliative care, I think, has come a long way. Some years ago when we debated in the house the issue of euthanasia, I took the opportunity to visit the palliative care unit at St John of God Hospital Murdoch and that helped me come to my conclusion that I would not support euthanasia. However, probably closer to home with regard to palliative care these days is the situation of my own 81-year-old mother who, unfortunately, through an incident that occurred and through age and other sorts of things, suffers from chronic pain through spinal stenosis and a crush fracture of L4 and L5. As anybody in this place who has had a back problem knows, it can be excruciating and quite horrible. The course of action that the gerontologists and neurosurgeons suggested for my mother was a very strong regime of pain medication. We put her on that pain medication but the medication itself did not really deal with the pain except for dulling down her senses. At that point, if euthanasia had been available, I think that on some days she may have made the decision: "I can't put up with this pain. These drugs aren't doing me any good. I'm going to end it all. I've already reached 80. Why should I go on?" People may have had some sympathy for that decision, but I was not prepared to accept what was happening to her and thought that we could look at other measures. Palliative care, remember, is the way to improve the quality of life of patients and their families facing life-threatening illness through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems. That is the definition of palliative care that comes from the World Health Organization. In my mother's case, therefore, I thought that this was not good and that we would look at other treatments that were available. I am really happy to report to the house that through some new advances that have been made in medicine—new advances are happening every day—she has now had what is called a neurostimulator fitted to her spine. She has done a trial of that and has found that she has had a pain reduction of over 75 per cent from the pain she previously had, and is now no longer taking drugs such as gabapentin and morphine and all sorts of other things that she was on for pain. All of a sudden we have this 81-year-old who has re-found her love of life and vibrancy, and is out there having a great time. I think that is a really good example of how we can look at palliative care.

These days we live in this throwaway society. I share the Leader of the Opposition's suggestion that most of us around the house are sort of in the same generation. I would like to think I am in the same generation as Hon Nick Goiran but I know that he is a little younger than me. Never mind! However, we lived in a society when, if appliances and things around our home were broken—dishwasher, refrigerator or television—we would get a technician to come in and fix them. There are people who had television sets that were 25 years old and they were working perfectly because they had been fixed along the way. What we are told today with all these appliances we buy is, "Oh, look, they've only got a limited life anyway, so if they're like four or five years old and they are broken, throw them away and get another one." It is all very well to do that with appliances such as printers, computers and things like that; we cannot do that with a human life. We cannot just throw away a child because the child is blind or has a mental disorder and get another one. I have only one child. I have my

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beautiful, gorgeous 16-year-old boy and he is the only child that I will ever have. I will never ever throw away that child, because we cannot replace human life. That is what we are talking about in this motion—that in places such as Belgium somebody could be euthanased because they have a mental disorder or they are blind! I hope with all of my heart that nothing ever happens to my son that would disable him or have him suffer any sort of mental illness. But if it does, I can guarantee the house that it would never ever be an option for me, for my husband or for any of my extended family to think, “Well, let’s just euthanase him and get another one.” We cannot do that. All members sitting in the chamber now should think about their children. Hon Donna Faragher has two beautiful children; they are absolutely gorgeous. Hon Nick Goiran has four children and Hon Phil Edman has two children. Those members are thinking about their kids now. I think that Hon Peter Katsambanis has five children and I am not sure whether he has stopped yet!

Several members interjected.

Hon LIZ BEHJAT: Okay, so most of us have children, and this is what it comes down to at the end of the day. We can stand in this place and spout statistics and talk about definitions and things that are happening, but we need to bring it back to our own situation. What would we do? I would do everything I could to protect human life for any member of my family, whether it be my mother at one end of her life or my son at this end of his life.

Palliative care certainly is the way to go. In August last year, we announced that \$19.5 million over four years would be spent to strengthen palliative care services for the Western Australian population. I join the Leader of the Opposition in the call for more facilities, such as those at St John of God Murdoch Hospital, to help people who have palliative care. The head of palliative care at Joondalup Health Campus, Dr Farid Taba, is a very close family friend of mine and he is doing some excellent work in that area. Advances are always being made to help people. Obviously, people do suffer, but one woman I spoke to on the day we went to Murdoch had been suffering because she was on the wrong drug regime. Once she got to St John’s Murdoch and the staff sorted out her drug regime, she said, “I know I’m not going to get better and I am going to die. Had it been four weeks ago, I would have asked to be euthanased because the pain was so bad. I’ve come here, they’ve sorted out my drug regime and I’m going home on the weekend. I have a few weeks left and I’m going to use every one of those days to spend time with my family while I can. When the end comes, I know I can come back here and I will be looked after in a way that there will be no loss of dignity for me. Hopefully, there will be no pain associated with that because the drug regime is right and I will be able to say goodbye in the way that I want to.”

Euthanasia in any form is not acceptable for this society. We are not a throwaway society. We do not throw away human life; we value it, we cherish it and we do whatever we can to extend it and to help people. I commend Hon Nick Goiran for bringing this motion to the forefront.

HON ROBIN CHAPPLE (Mining and Pastoral) [12.13 pm]: As members would know, I have introduced voluntary euthanasia legislation on two occasions in this place, and it is my intention to do so again. However, I think we need to be careful with a motion such as this one because it has little relevance to legislation that has been introduced in Western Australia or Australia generally and it references issues in other jurisdictions.

My legislation had been very clear in the past that nobody under the age of 21 years could be an applicant for voluntary euthanasia. The reason is that the legislation had two components. We wanted to stop euthanasia tourism, so the legislation stipulated that someone would have to be registered as a resident of Western Australia for three years and the person had to be over 18 years, which is why the age moved to 21. I just wanted to explain that. The legislation introduced by me and others around Australia and, indeed, before me, the Australian Democrats in this place, made it clear that no person would be compelled to do anything that was against their wishes, whether for religious reasons or otherwise. That is important.

Voluntary euthanasia is supported in Western Australia. In October 2009, Newspoll did a nationwide euthanasia study. It was surprising that WA came out as the highest supporter for voluntary euthanasia, with 86.3 per cent of the capital city area supporting voluntary euthanasia and, believe it or not, 92.1 per cent of country people supporting voluntary euthanasia. Therefore, this is not an issue that will go away.

I respect the positions and views of Hon Nick Goiran and those people who oppose voluntary euthanasia as much as I respect the views of the Leader of the Opposition who gave, I felt, a very, very good overview of the situation as she sees it. There is no compulsion in voluntary euthanasia. I do not say to someone, “I think you’ve done your time; it’s about time you shuffled off.” However, the key issue is about compulsion. Those people who do not support voluntary euthanasia do not have to be involved in, make application for or be subject to voluntary euthanasia. The key point is that we provide an avenue for those people who, at the final time of their lives, through pain and suffering, wish to have a peaceful exit from this world.

Quite clearly, the legislation that we introduced in this place had many, many checks and balances to ensure that the person was of sound mind. That was to be checked twice. Nobody with anything other than a diagnosed

terminal illness could be an applicant for voluntary euthanasia. The person would have had to be aged 21 years and over, an ordinary resident of Western Australia for the previous three consecutive years and able to communicate his or her intentions. The legislation did not provide an ability for anyone else to say, “Aunt Mabel needs to depart; we don’t think it is in her best health, mental or pain interests to remain.” There was no ability for anybody to propose that somebody be euthanased. That is unfortunate in one regard because currently the process in our hospitals, where 30 per cent of doctors admit to providing doses of double effect, is that doctors provide doses of double effect without the patient’s recognition. Therefore, voluntary euthanasia legislation provides much more surety and in fact protects those doctors who, by their very admission, are breaking the law. We need to resolve those issues. As I said, under my legislation and other Australian legislation, a person has to have a diagnosed terminal illness with an expected outcome of death within two years, has to be experiencing pain, suffering or debilitation related to the relevant terminal illness and has repeatedly stated via written communication that they have no desire to continue living.

One thing that I would like to touch on is that palliative care is certainly the way to go. We really need a funding package that deals with that. There is one palliative care nurse in the Kimberley, who does her palliative care by phone to Fitzroy Crossing, Halls Creek and Kununurra. That is how palliative care is administered in the Kimberley. We have talked about the great examples of palliative care in Perth, but, unfortunately, they are for the favoured few. Therefore, we need to do something major about palliative care. Many doctors and nurses who work in the area of palliative care say that even with the best palliative care, even in those environments, we reach the point at which people come to the end of their time in pain and suffering and requests to end that are often made. The unfortunate thing is that the requests are made in isolation of any legal structure. Unfortunately, even in palliative care, doses of double effect are applied.

I take on board everything that has been mentioned in the motion of Hon Nick Goiran. I respect the views of all individuals. I think we need to respect the views of others in their desire for a voluntary euthanasia regime. As I have said, 91 per cent of country members are supportive of voluntary euthanasia. There needs to be some respect. We cannot impose our sociological, religious or whatever views on others. We need to listen to and empower individuals, not impose on them a regime based on somebody’s views of what is right or wrong. Those views that are right or wrong are the genuine, valued property of the individual, and I respect that. We are not saying that voluntary euthanasia legislation will impose anything on people who do not wish to participate. That is the clear distinction. It is unfair for those people who have a fervent view against euthanasia to try to impose a view on the general public that is not the general public’s accepted view.

There is not much more that can be said on this issue. On the comments about Dr Philip Nitschke, I have my own set of problems with Dr Nitschke. I have met him. I do not think he does the movement of voluntary euthanasia a great deal of benefit. However, having said that, innumerable people who go to his forums need his advice because there is no other option. I would like a system in which we do not need to go to the Philip Nitschkes of this world to seek some relief in our dying days.

HON PETER KATSAMBANIS (North Metropolitan) [12.22 pm]: I rise to speak on this motion and, in doing so, I congratulate Hon Nick Goiran for bringing this important and detailed motion to the house. It cannot be said that Hon Nick Goiran shies away from the tougher subjects and the subjects that challenge us, particularly our thoughts about the sort of society that we want to live in. Last year he brought to the house a motion highlighting the very important issue of elder abuse, and again this year he has brought before us this motion that covers a number of areas. It is extremely comprehensive. In the time allotted to me, it will be impossible for me to do justice to all the areas that Hon Nick Goiran has highlighted in the five-part motion he has put before the house. I put on the record that I do not take issue with much or any of what he has moved. I am supportive of the positions that he has enunciated to the house and to the community through the motion he has moved, and I once again congratulate him for doing so.

Instead of trying to cover every area, I will try to cover as many of these areas as I can today. As I have said, some of them go to the core of the type of society that we want to live in. The concept of children being euthanased is abhorrent. Just the thought that people will choose to end a young person’s life in the way that has recently been permitted by the Belgian Parliament is anathema to me, and I expect that it would be anathema to the vast majority of our society. It is difficult to talk about it without getting emotional. We know that life is precious. We know that people have struggled to bring children into the world, so the concept that people would willingly choose to take a child’s life is beyond the realm of my own contemplation of the sort of society that I want to live in. I hope we never go down that path.

It is the same with the other issue raised in the motion about practices that are occurring in Belgium and the Netherlands around assisted suicide and the death of people who do not have a terminal illness but suffer from either psychiatric disorders or physical disabilities. When we stop to contemplate what that means, the message

that that sends out is again abhorrent. I think it attacks the core of how I feel society should deal with people who struggle with either mental illness or some physical disability. Over centuries, our society has attempted to deal with people who suffer from either mental illness or physical disability in as an accommodating way as possible. Particularly over my lifetime, I think we have come a long way. I remember in the 1980s when we had the International Year of Disabled Persons, which led to a real focus on how we can not only make life better for people with physical disabilities, but also encourage the whole of society to view these people as full contributing members of society, which they are. We have done the same in the realm of psychiatric or mental illness over the past 20 or 30 years. We have recognised that these people need assistance and that we need to provide that assistance. When we provide that assistance, in the vast majority of cases, these people are able to live well-fulfilled lives, be contributing members of society, enjoy their own lives and fulfil the lives of the people around them. I think we have done wonderfully well in that area and, as a society, we deserve a lot of credit, but there is a long way to go. There is still discrimination, a lack of understanding and probably a lack of service provision because there is only so much we can provide at any one time. However, in the main, our society has done very well to send a strong message that not only do we care about these people and want to provide them with treatment, but also we view them as equal, contributing members of our society, we value them and we do not want to see them thrown on the scrap heap or considered as second-rate members of society.

When we flip that around and consider what this motion suggests is happening in places such as Belgium and the Netherlands, we should think of the emotional impact that that has on those very people whom we have tried to assist and whom we have worked very hard to make full and contributing members of society. What sort of message are we sending to those people if we effectively say that if they suffer from a psychiatric illness or a physical disability, they should take their life and, if they cannot do it themselves, the state will assist them? The industry of death that is attempting to build up around this type of abhorrent behaviour is encouraging that to happen. It is disgusting; it debases us as a society. It does not make a comment on those people who are being “permitted” to go down that path; it is really a comment on our society. It takes us backwards to those times when people with physical disabilities or people with psychiatric problems were locked away in dark rooms and in institutions and treated as second and third-rate citizens; they were hardly treated as citizens at all. We have come so far from there and we should be proud of that. We have got further to go but we should be proud of how far we have come. We should continue to move down that pathway to assist those people to overcome their afflictions and to send them the strong message to boost their self-esteem: “Look, you are a full part of this society, and we will help you fulfil your destiny in life, not end your life.”

I commend Hon Nick Goiran for bringing this motion to the house. It is legally not happening in this state and legally not happening in this country, but whether it is happening illegally or not, it is that sentiment or message that is being sent that is critically important. A lot of these people, I understand, have dark moments; they have times when they do not feel good about themselves. We have spent so much to provide services to those people. Just in this state, we have the WA suicide prevention strategy, which has achieved strong community engagement. There are 45 community action plans implemented across 255 locations at a cost of \$13 million. They are doing a good job.

In response to the issues around self-harm and suicide amongst school-aged children, \$1.38 million has been invested over the past two years for additional mental health clinicians in child and adolescent mental health services. We have an additional school psychologist based at the Department of Education; and, of course, organisations like Youth Focus and Lifeline have been given additional multimillion-dollar funding over the last few years to increase their range of services to provide assistance to people who are having dark thoughts to pull them away from the brink of suicide. Having done all that, let us not go back the other way and justify this legalised killing; it is wrong.

The DEPUTY PRESIDENT: Members, unfortunately due to the time commitment, I will have trouble trying to allocate the call to everyone. Given this it is non-government business, I think it is appropriate that I give the call to Hon Rick Mazza.

HON RICK MAZZA (Agricultural) [12.33 pm]: I was not going to speak on Hon Nick Goiran’s motion today, but I felt somewhat compelled to because I absolutely and fully support it. I know through personal painful experience the despair of having a child who wants to end their life through depression. It was through a lot of family support and love that that person was brought back from the brink of wanting to end his life. I am happy to report today that he is a well-rounded, well-balanced happy individual enjoying life. Anybody who now meets him for the first time would have no idea of the depths of despair that he was in a few years ago. It is all about suicide prevention. The last thing we should do is normalise suicide by making it a legal option.

I understand that there are terminal cases and that people do suffer a lot of pain. There are elderly people who have diseases like emphysema. I have experienced that end of the scale as well with elderly relatives, and not so

Hon Nick Goiran; Hon Sue Ellery; Hon Liz Behjat; Hon Robin Chapple; Hon Peter Katsambanis; Hon Rick Mazza; Hon Donna Faragher

elderly relatives who have cancer. We all understand that palliative care is a balance between pain management and easing someone out of life. It is a balance between keeping them comfortable and knowing that morphine or the pain medication treatment they are taking for pain management will eventually end that life. We already have a system in place to make people as comfortable as they can be to exit life, and I truly believe we should be focusing on suicide prevention in our community. The last thing we ever want to do is normalise suicide as an option.

HON DONNA FARAGHER (East Metropolitan — Parliamentary Secretary) [12.35 pm]: I also rise to say a few words about Hon Nick Goiran's motion. Although my comments are perhaps more pertinent to the part of the motion dealing with suicide prevention, like Hon Nick Goiran and I think every person who has spoken today, including Hon Robin Chapple—we know his position on this matter, and I accept that—we share the same concern about the Belgian government's decision to allow children of any age to access assisted suicide.

I heard Hon Robin Chapple asking why we are debating this, given that child euthanasia has not been put forward in any legislation in either this Parliament or other Australian Parliaments. I think the reason for bringing it to the attention of this house is to make sure it never happens. I hear what Hon Robin Chapple said; namely, his proposal was for people 21 years of age and above. I appreciate the issue of euthanasia is highly emotive. There are those in our community who are vehemently opposed to it and those who strongly support it; and there are people within the community who may not have a position either way. I certainly hope, for even those who are the strongest advocates for the right to die, that the notion of extending it to children would be met with considerable alarm. Hon Liz Behjat made a very sage point—that is, we should think about it in terms of our own children. It is abhorrent to think of it in that way.

In looking at the motion more generally, there has been much discussion about palliative care, but the other key issue in the motion is suicide prevention. It concerns me greatly that we see quite alarming figures of the number of young people who are committing suicide or intentional self-harm. The reasons that people choose to commit suicide are indeed complex; it is not something that anyone in this house can perhaps fully appreciate, but it is deeply concerning. I will refer to an article published in *The Australian*, which reported that in 2012 suicide was the leading cause of death among Australians aged 15 to 24, claiming the lives of 214 boys and young men and 110 girls and young women. Further, and very disturbingly, it reports that 57 children aged 13 and younger had killed themselves between 2008 and 2012. These are children who are not even teenagers yet. Those figures alarmed me, as I am sure they did every member in this house. It is for those reasons that organisations such as Youth Focus, which Hon Peter Katsambanis mentioned, do such tremendous work within our community. Each year they see—this is tragic—around 2 000 young people and there are thousands who access their preventative and education programs as well. The work that they do is absolutely incredible. As a counsellor working with youth, I do not know how they do it; it must be one of the hardest jobs to work with young people who are at risk of committing suicide. They do such an important job, and hearing Hon Rick Mazza's experience of someone who has changed their life is a very good thing.

Motion lapsed, pursuant to standing orders.