Living and Dying Well Evidence to the Northern Territory Government 01/02/2023

Living and Dying Well (LDW) is a UK-based think tank set up to work on end-of-life issues, particularly revolving around assisted dying. We are writing to submit our evidence to the Northern Territory's assisted dying public consultation. Our organisation's members have vast amounts of experience in different fields and approach assisted dying from very different perspectives:

- Baroness Finlay of Llandaff a palliative care physician with over 35 years of experience.
- Baroness Grey-Thompson is a Paralympian and prominent disability rights activist in the UK.
- Lord Alton of Liverpool has been a high-profile Parliamentarian for over 40 years, serving both in the House of Commons and the Lords.
- Dr Carol Davis, who in 1995 began the Hospital Palliative Care Team at Southampton General Hospital and has worked in Southampton ever since in the community, hospice and, mainly, acute hospital.

LDW has analysed the data from every jurisdiction that has legalised 'assisted dying' and which have available annual reports into their assisted deaths. The term 'assisted dying' is a broad euphemism covering physician assisted suicide (as in Oregon) and euthanasia (as the majority of such death int eh Netherlands and Canada). We have found concerning trends in many of these jurisdictions and a worrying lack of data from several more.

Some jurisdictions are more permissive than others, resulting in very different experiences with 'assisted dying'. We have therefore provided a spread of data to assess the experiences of the most permissive and the most restrictive jurisdictions. Here are some of our key findings from Oregon, Washington (state), Canada, Belgium, the Netherlands and Victoria (Australia):

1. Prolonged dying – Oregon State, USA: The Oregon Health Department official reports over 25 years reveal that 9 patients regained consciousness; none of these were reported as proceeding to a second ingestion of lethal drugs. The median time from ingestion to death is only available on 56% of the 2454 deaths in 25 years; last year (2022) the median time reported had risen to 52 minutes (range 3 minutes – 68 hours). Overall, in 25 years, half of patients with timings recorded took from 30 minutes up to 104 hours to die after ingestion of lethal drugs.[1]

2. Complications – Oregon State, USA: The presence or absence of complications was recorded in only 40% of deaths (60% were not recorded). 11% of patients, where the presence or absence of complications was recorded, suffered complications from drug ingestion before death between 2010-2022. Prolonged time to death and reawakening are not recorded as complications by Oregon.[2]

3. Washington State, USA: Their 2021 Health Department official report states that 54% died within an hour of ingestion. 16% took longer than 120 minutes (although, no further times are specified). The time between ingestion to death in 14% of cases is undocumented. No record of complications is kept.

4. Washington State, USA: Before taking the lethal drugs, applicants are asked for the most significant reasons they have applied for an assisted death. In 2009, the first year on record, 23% of patients said they applied not necessarily because they wanted to die, but because they felt like a burden on their families or caregivers. In 2022, this had become the case for 59% of applicants.

[1] Oregon Health Authority, '*Oregon Death with Dignity Act: 2022 Data Summary*', [Link]
[2] Ibid

Similarly, in 2009 2% of applicants applied because of the financial implications of treatment.[3] In 2022, this was now 10%.[4] In 2019, Washington stopped reporting any data relating to complications despite multiple complications being reported each year between 2009-2018 (except for 2010 when no complications were reported).[5]

5. Failure of safeguards: A case from Canada illustrates the fallibility of diagnosis when a 71-year-old, told he was terminally ill with end stage chronic obstructive pulmonary disease (COPD), was euthanised within 48 hours of first assessment, but autopsy revealed he did not have COPD.[6]

In Belgium in 2013, 1.7% of all deaths were a result of a hastened death without an explicit request from the patient[7], and in 2016, in almost 25% of cases the proper procedures or precautions were ignored in some way. [8]

The Oregon Health Authority has confirmed that 'terminal illness' includes conditions which, with treatment, may not be terminal. [9]

7. Autonomy: The concept of autonomy is complicated. Firstly, autonomy is never the only principle at play in these situations. We would not allow every person who wants to end their lives the possibility to do so. Instead, doctors have to enter into deliberations for and against a request for assisted dying in each individual case to determine whether the patient's premature death should be facilitated or not i.e. their ongoing life has no worth. It becomes not a question of whether people have a right to say that they are unworthy. It becomes a question of whether they have a right to be believed when saying it. Secondly, individuals do not exercise their autonomy in isolation. Instead, we are relational beings operating in social contexts where the opinions, attitudes and perceptions of others shape the autonomous decisions we make. Pressures on a patient don't have to be direct or articulated to shape their decision. Instead, individuals translate the attitudes of those around them into their autonomous decision making. If all of society does not believe in the value of the individual's life, how can we be sure that the individual's personal decision to die is not being shaped by society?

8. Several examples highlighting how heavily autonomy can be impacted by external pressures have emerged from Canada. People who made no inquiry into accessing an assisted dying service have reported being offered death as if it was a default treatment option.

Christine Gauthier is a Canadian veteran and Paralympian who uses a wheelchair. She reported to the Canadian Parliament that when she requested a wheelchair ramp to her house, as she is entitled to, she was instead asked if she would like an assisted death.[10]

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[3] Washington State Department of Health, '2009 Death With Dignity Act Report', [Link]
[4] Washington State Department of Health, '2022 Death With Dignity Act Report', [Link]
[5] Washington State Department of Health, '2019 Death With Dignity Act Report', [Link]
[6] Coelho, Ramona, '*Medical Assistance in Dying Overused in Canada Even Before Expansion*', The London Free Press, 11th July 2022. [Link]
[7] Chambaere, Kenneth; Cohen, Joachim; Deliens, Luc; Mortier, Freddy; Stichele, Robert V., '*Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium*', The New England Journal of Medicine (372;12), 19th March 2015. [Link]
[8] https://www.ieb-eib.org/ancien-site/pdf/20161019-rapport-euthanasie-2014-2015.pdf
[9] Stahle, Fabian, '*Oregon Health Authority Reveals Hidden Problems with the Oregon Assisted Suicide Model',* Scoop, January 2018. [Link]
[10] Tom Yun, 'Paralympian Trying to get Wheelchair Ramp says Veterans Affairs Empoyee Offered Her Assisted Dying', CTV News, 3rd December 2022. [Link]

Kathrin Mentler, a 37-year-old Vancouver resident, attended a hospital seeking urgent support for her mental health and suicidal ideation. She was instead offered an assisted death by the staff.[11]

A paper written by Canadian bioethicists Kayla Wiebe and Amy Mullin said, "In 2022, an individual in Canada, who had been diagnosed with multiple chemical sensitivities (MCS), received MAiD (Medical Assistance in Dying). However, by their own description, their decision to choose MAiD was driven primarily by the fact that they were unable to access affordable housing compatible with MCS. While it was true that they suffered from an illness, disease or disability that caused 'enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions that they consider acceptable' as specified under the eligibility criteria of Bill C-14, the primary source of their suffering was an inability to find appropriate housing, not the condition itself".[12]

9. Victoria, Australia: A key argument that was used by campaigners in favour of legalising assisted dying in Victoria was that assisted dying would reduce the number of suicides. '*Unassisted suicides amongst the over-65s have increased from 102 in 2018 to 156 in 2022, showing a clear upward trend since VAD was implemented in 2019'.*[13]

10. Underreporting and lack of transparency: A review of the laws in The Netherlands and in Belgium in Current Oncology in 2012 at section 2.2 states:[14]

> "Reporting is mandatory in all the jurisdictions, but this requirement is often ignored [11,12] In Belgium, nearly half of all cases of euthanasia are not reported to the Federal Control and Evaluation Committee [13]. Legal requirements were more frequently not met in unreported cases than in reported cases: a written request for euthanasia was more often absent (88% vs. 18%), physicians specialized in palliative care were consulted less often (55% vs. 98%), and the drugs were more often administered by a nurse (41% vs. 0%). Most of the unreported cases (92%) involved acts of euthanasia, but were not perceived to be "euthanasia" by the physician. In the Netherlands, at least 20% of cases of euthanasia go unreported [7]. That number is probably conservative because it represents only cases that can be traced; the actual number may be as high as 40% [14].
>
> Although reporting rates have increased from pre-legalization in 2001, 20% represents several hundred people annually."

11. A Belgian study estimated the total number of cases of euthanasia in Flanders in 2007 was 1040, of which approximately half (549) were reported to the Federal control and evaluation committee.[15] Where physicians perceived they had shortened life by over one week, reporting rates were higher (93%).

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[11] Christa Dao, Elizabeth McSheffrey, *'She Went to Hospital with Suicidal Thoughts. A Clinician Raised Medically Assisted Death'*, Global News, 10th August 2023. [Link]

[12] Kayla Wiebe, Amy Mullin, '*Choosing Death in Unjust Conditions: Hope, Autonomy and Harm Reduction'*, BMJ Journal of Medical Ethics, July 2023, [Link]

[13] David A Jones et al, '*Did the Voluntary Assisted Dying Act 2017 Prevent "At Least One Suicide Every Week"?'*, Journal of Ethics in Mental Health, Vol. 11, 2023. [Link]

[14] Pereira, Jose, '*Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls'*, Current Oncology, Vol. 18(2), April 2011. [Link]

[15] Bilsen, Johan; Cohen, Joachim; Deliens, Luc; Mortier, Freddy; Rurup, Mette; Smets, Tinne, '*Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross-Sectional Analysis of Reported and Unreported Cases'*, BMJ, October, 2010. [Link]

12. Netherlands: A survey of physicians in the Netherlands in 2005 revealed that only 80% of 'euthanasia cases' were reported to the review committees. Euthanasia with non-recommended drugs was almost never reported.[16]

13. Adequacy of data collection and evidence of coercion: although the Netherlands requires summary case reporting, there is no independent review of the consultations in which the request for euthanasia/assisted suicide was conducted. In other jurisdictions data collection is mostly demographic and not qualitative. It therefore is impossible to state that there is no coercion or pressure behind the request, because there has been no attempt to assess such influences before death. Of the 27 jurisdictional areas that legislated for assisted dying, only 16 regularly produce reports from which data can be gathered, and this is mostly demographic (see table 1 below).[17]

14. However, when comparing the world rankings for palliative care provision between 2015-2021, nations that has implemented 'assisted dying' fell in rank, except for Switzerland. Over this period there have been global initiatives to improve palliative care. This period is also when 'assisted dying' deaths increased significantly in countries with legislative change (Graph 1, next page).

Nation	2015 ranking[18]	2021 ranking [19]	
UK	*1st*	*1st*	*No legislation on AD*
Ireland	*4th*	*2nd*	*No legislation on AD*
Australia	2nd	4th	Declined
Netherlands	8th	No data	Declined
New Zealand	3rd	12th	Declined
Switzerland	15th	13th	Improved
Canada	11th	22nd	Declined
Belgium	5th	26th	Declined

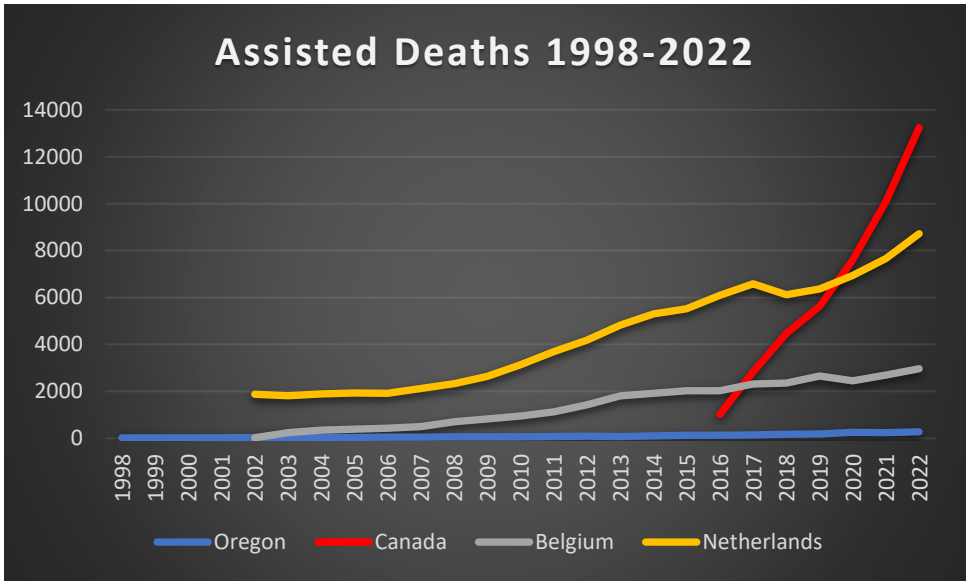
[16] Buiting, Hilde M.; Heide, Agnes van der; Maas, Paul J van der; Pasman, H. Roeline W; Onwuteaka-Philipsen, Bregje D; Mette L Rurup, '*The Reporting Rate of Euthanasia and Physician-Assisted Suicide: A Study of Trends',* Medical Care, Vol. 46(12), December 2008. [Link]

[17] Worthington, Ana, '*Comparison of Official Reporting on Assisted Suicide and Euthanasia Across Jurisdictions*', BMJ, 8th December 2022. [Link]

[18] The Economist Intelligence Unit, '*2015 Quality of Death Index: Ranking Palliative Care Across the World*', The Economist, 7th October 2015. [Link]

[19] Baid, Drishti; Bhadelia, Afsan; Bhatnagar, Sushma; Connor, Stephen R.; Goh, Cynthia; Singh, Ratna; Finkelstein, Eric A., '*Cross-Country Comparison of Expert Assessments of the Quality of Death and Dying 2021*', Journal of Pain and Symptom Management, April 2022, Vol. 63 (4). [Link]

15. Increases in numbers are seen in all jurisdictions over time (Graph below). Data from Victoria Australia, not included below, has only been available for 4 years (from July to June); currently appears to reflect the rate in deaths per million population seen in Oregon which is rising annually but at a lower rate than those countries that legalised medical euthanasia.



16. Poor decision-making in vulnerable people. There have been numerous reports into vulnerable people making decisions for themselves that are not in their own best interests.[20] Furthermore, there have been cases of their best interests not being met despite their families' wishes. A Mencap report, Death by Indifference, was written in 2012 and documents 74 such deaths within the NHS. It shows both that disabled patients were not treated with their best interests at heart, and that the process for making decisions for people who lack capacity (required by the Mental Capacity Act 2005) was ignored.[21]

[20] '*Protect, Respect, Connect, - Decisions About Living and Dying Well during COVID-19',* Care Quality Commission, 15th April 2021, [Link}

[21] '*Death by Indifference: 74 Deaths and Counting'*, Mencap, 2012, [Link]

2023 Danish Ethical Council Assisted Dying Report:

The Danish Ethical Council have published a new report following a comprehensive investigation into assisted dying during which they considered the two models of assisted dying seen in Oregon and the Netherlands. You can access the Danish National Centre for Ethics' website and download the original report by clicking here.[22] Alternatively, you can access a translated PDF of the report here.[23]

The Council's investigation was commissioned by the Danish Parliament's Health Committee on 29th June 2023. The Council concluded that, "on the present basis, there are no members of the Ethics Council who find the Oregon model or the Dutch model sufficiently clear in their delineations, fair in their justifications for access, or sound in terms of control mechanisms". On whether they would support the implementation of either Oregon or Dutch-style assisted dying in Denmark, "no member of the Ethics Council has wanted to recommend such a solution".

The report is comprehensive and very balanced in its assessment of the issues that surround assisted dying, giving serious consideration to reasons both for and against. Access to palliative care and how it could work in conjunction with assisted dying was one of the topics discussed. Overall, "the members consider euthanasia to be in conflict with palliative care and are therefore against the legalization of euthanasia as long as we as a society have not exhausted the possibilities for relief."

The report also addressed fears that the law could be expanded over time, allowing more people access to assisted dying than had originally been intended. Fundamentally, the Council posed the question, "what legislation has ever been able to guarantee that it could not be changed?".

Additionally, the Council felt deeper changes to society would occur should assisted dying be legalised. "The very existence of an offer of euthanasia will decisively change our ideas about old age, the coming of death, quality of life and what it means to take others into account. If euthanasia becomes an option, there is too great a risk that it will become an expectation aimed at special groups in society."

The Oregon and Dutch models of assisted dying are very different. Oregon's laws are more limited in scope compared to the famously expansive Dutch laws. Having thoroughly examined two very different models of assisted dying that both pro and anti-assisted dying campaigners frequently refer to, the Council felt that it cannot be regulated in a satisfactory and safe manner.

[22] Nationalt Center For Etik, "The Ethical Council's Opinion on Euthanasia", October 2023, [Link].
[23] Living and Dying Well, "Denmark's Ethics Council Advises Against the Legalisation of Assisted Dying", November 2023, [Link]

Expansion of legislation:

Oregon's 1994 legislation initially contained a waiting period of 15 days between first and second oral request, before suicide could be assisted in terminally ill patients. In 2020 this was waived if the person is expected die to in the waiting period.[24]

In The Netherlands in 2001, euthanasia was legalised for people over 12 years old.[25] In 2005 the Groningen Protocol for euthanasia of neonates and infants was declared to be mandatory by the Dutch Society for Paediatrics. In 2018 the Dutch Euthanasia Commission Code included the possibility of couples requesting 'double euthanasia'.[26] In 2020 the Dutch Supreme Court ruled that doctors can end the life of patients with dementia/ Alzheimer's based on an advanced request.

In Belgium the 2002 legislation for euthanasia of adults was expanded in 2014 to include competent minors. 2020: An amendment removed any time restriction on advance directives for euthanasia.

In Canada part of the 2016 Medical Aid in Dying was declared unconstitutional by the Superior Court of Quebec and in March 2021 the House of Commons legislated to remove the 'reasonable foreseeability of natural death' requirement. A waiver of final consent was introduced if the patient loses decision making capacity. Implementation of the mental illness as a sole reason for providing MAiD will now be implemented in March 2024.

Telehealth services being used for assisted dying consultations and assessments has caused serious concerns in Australia among many health care professionals. A letter written by Maria Cigolini on behalf of the "Health Professionals Say No!" network has drawn attention to concerns over such expansion, including past experience of telehealth services during the Covid-19 pandemic. Many oncologists reported that the cancer care delivered via this method was frequently 'suboptimal'.[27]

[24] Oregon Health Authority, *'Frequently Asked Questions',* [Link]

[25] '*Dutch Law on Termination of Life on Request and Assisted Suicide (Complete Text)',* World Federation Right to Die Societies, 1st April 2002. [Link]

[26] '*Euthanasia Code 2018: Review Procedures in Practice',* Regional Euthanasia Review Committees, 10 January 2019, p. 30. [Link]

[27] Maria Cigolini, 'Open Letter to the Federal, State and Territories Attorneys-General Concerning Proposed Legislative Changes to Permit Telehealth for Voluntary Assisted Dying (VAD) Practices', Health Professionals Say No!, April 2023. [Link]

Euthanasia and Physician-Assisted Suicide in People with Intellectual Disabilities and/or Autism Spectrum Disorders

Every year, the Dutch government publishes a few anonymised case reports of people who have received Euthanasia or Assisted Suicide (EAS) by a physician. The reporting of all EAS cases is a legal requirement in the Netherlands, and after performing EAS a physician must report it to one of the 5 regional review committees. The case reports are scrutinised by the committee, which publishes a small selection of anonymised case reports in an Annual Report, plus a wider selection online. This is freely available to the public.[28]

There are 927 such reports publicly available (in Dutch) for the 10-year period from 2012 to 2021- this is 1.5% of the total number of people receiving EAS. We have searched this database for cases of people who had intellectual disabilities and/or autism. We found 39 such case reports. An example of such a report can be found here.[29] Professor Tuffrey Wijne undertook a content analysis of the texts of all 39 reports:

"We analysed all case reports we could find where the person receiving EAS had intellectual disabilities (ID), autism spectrum disorders (ASD) or both. The **39 identified cases are 4.1% of the total number** of cases published on the RTE website. It is important to note that these numbers may not be representative of the actual numbers or percentages of people with ID and/or ASD who received EAS; it could be that the complex nature of many such cases makes them more likely to be selected for publication. It is also possible that we have missed some cases where the person had ID or ASD. The case selection was based on the descriptions and terminology in the case reports and may therefore not be comprehensive. For example, an ASD diagnosis was sometimes mentioned just briefly once, so it may be that some patients with ID or ASD have not been noted within the dataset.

"It is not possible, therefore, to know how typical the selected case reports are, or how common or representative the stated co-morbidities and causes of suffering are within the population of people with ID or ASD; nor is it possible to make clear comparisons with other groups of patients (for example, those with mental health problems but without ID or ASD). However, as the RTE states, these EAS reports have been selected for publication because of their importance in the development of societal norms and standards and to give physicians insight into the RTEs considerations. As such, they serve as guidance for physicians' decision-making in the future. Therefore, exploring the reasons for requesting and granting these 39 EAS requests is of considerable importance."

The following details are cited from this paper.[30] We reviewed 39 cases (not 38, which was the number given in the evidence session). Not all of those had euthanasia simply because of LD/ASD, however in 24 cases, LD/ASD was either the main factor or a major contributing factor in the decision to ask for (and grant) euthanasia. In 15 cases, the main reason was not described as substantially related to their ASD or ID.

In 8 cases (21%), the only causes of suffering described were factors directly associated with ID or ASD. Typically, these people were unable to live with the characteristics of ASD/ID and could not cope with the world. In 8 cases (21%), ASD or ID made it difficult to cope with non-life-threatening somatic

[28] Regional Euthanasia Review Committees' Homepage [Link]
[29] '*Judgement 2021-26',* Regional Euthanasia Review Committees, 13th April 2021, [Link]
[30] Curfs, L; Finlay, I; Hollins, S; Tuffrey-Wijne, I, '*Euthanasia and Physician-Assisted Suicide in People with Intellectual Disabilities and/or Autism Spectrum Disorders: an Investigation of 39 Dutch Case Reports (2012-2021)*', BJPsych Open, (2023 in press)

symptoms or physical decline, such as age-related conditions or symptoms (n=5), tinnitus (n=2) or curable cancer (n=1).

In a further 8 cases (21%), ASD/ID was a major contributing factor to the person's inability to cope with their psychiatric condition; or the main causes of suffering were described as a combination of psychiatric conditions and the characteristics associated with ASD or ID. In one case, there was an additional somatic cause of suffering (chronic fatigue syndrome).

In 15 cases (38%), the person's EAS request stemmed from suffering that was not described as substantially related to their ASD or ID, but related to psychiatric conditions (n=6), somatic conditions (n=6; all of these were people with ID) or a combination (n=3)".

The 39 cases we found were the minimum number and there may have been more, but we don't know.

Significant Differences in Data Collection Between Jurisdictions

Tables from: Worthington, Ana, '*Comparison of Official Reporting on Assisted Suicide and Euthanasia Across Jurisdictions'*, BMJ, 8th December 2022.

Table 1 Jurisdictions that prescribe and administer lethal drugs

	No of patients requesting an 'assisted death'	No of patients who received assisted suicide prescriptions or were approved for euthanasia	No of patients who died by assisted suicide or euthanasia	No of patients receiving assisted suicide prescriptions or approved for euthanasia dying from other causes	No of 'assisted dying' applicants assessed as ineligible	No of 'assisted dying' requests that were withdrawn	No of participating clinicians	Frequency of clinician participation	No of participating pharmacies
Australia (Victoria)	✓	✓	✓	✓	✓	✓	✓		
Belgium			✓						
Canada	✓		✓	✓	✓	✓	✓	✓	
Luxembourg			✓						
Netherlands			✓						
New Zealand	✓		✓		✓		✓		
Switzerland			✓						
California		✓	✓	✓			✓		
Colorado		✓							✓
Hawaii		✓					✓		
Maine		✓							
New Jersey			✓						
Oregon		✓	✓	✓			✓	✓	
Vermont		✓	✓	✓					
Washington		✓	✓	✓			✓		✓
Washington DC		✓	✓	✓			✓		

Data from 16 jurisdictions that produce reports.

Table 2 Patient Characteristics

	Condition that led to 'assisted dying' request	Gender	Age	Ethnicity	Education	Region of residence	Hospice or palliative care enrolment	Reason for requesting 'assisted dying'/ end-of-life concerns	Health insurance	Marital status	Living situation	Disability support services enrolment	No of patients referred for psychiatric evaluation
Australia (Victoria)	✓	✓	✓	✓		✓			NA		✓		
Belgium	✓	✓	✓			✓		✓	NA				
Canada	✓	✓	✓			✓	✓	✓	NA			✓	
Luxembourg	✓	✓	✓					✓	NA				
Netherlands	✓	✓	✓					✓	NA				
New Zealand	✓	✓	✓	✓					NA				
Switzerland	✓	✓	✓			✓			NA				
California	✓	✓	✓	✓	✓		✓		✓				
Colorado	✓	✓	✓	✓	✓	✓	✓			✓			
Hawaii	✓	✓	✓	✓	✓		✓		✓				
Maine	✓	✓	✓	✓	✓								
New Jersey	✓	✓	✓	✓	✓	✓				✓			
Oregon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓
Vermont	✓												
Washington	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Washington DC	✓	✓	✓	✓	✓				✓				

Data from 16 jurisdictions that produce reports
NA, not applicable.

Table 3 Clinician Characteristics

	Medical specialty of participating clinicians	Location of medical practice
Australia (Victoria)	✓	✓
Belgium	✓	
Canada	✓	
Luxembourg		
Netherlands	✓	
New Zealand	✓	✓
Switzerland		
California		
Colorado		
Hawaii		✓
Maine		
New Jersey		
Oregon		✓
Vermont		
Washington		
Washington DC		

Data from 16 jurisdictions that produce reports.

Table 4 Drugs and the dying process

	Location of patient death	Name of drugs prescribed	Time between first and second request for 'assisted death'	Time between 'assisted dying' request and death	No of patients who informed family of decision	Whether a healthcare provider was present at time of death	Duration of patient–clinician relationship	Time between drug ingestion or administration to loss of consciousness and death	Presence of complications after drug ingestion or administration
Australia (Victoria)			✓						
Belgium	✓	✓							
Canada	✓			✓			✓		
Luxembourg	✓	✓							
Netherlands	✓								
New Zealand	✓								
Switzerland									
California	✓				✓	✓			
Colorado	✓	✓	✓						
Hawaii		✓		✓					✓
Maine									
New Jersey	✓	✓							
Oregon	✓	✓		✓	✓	✓	✓	✓	✓
Vermont									
Washington	✓			✓				✓	
Washington DC									

Data from 16 jurisdictions that produce reports