HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

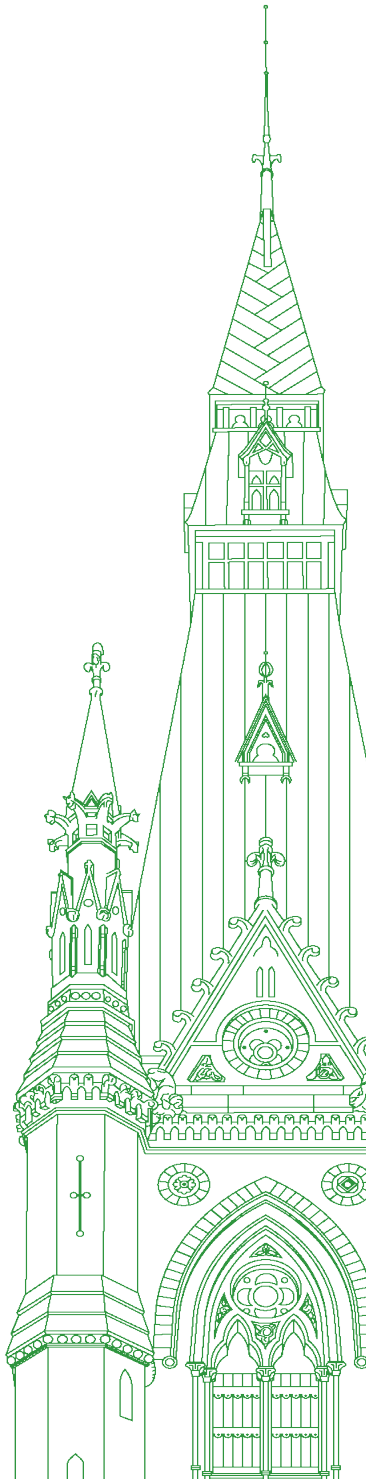
44th PARLIAMENT, 1st SESSION

Special Joint Committee on Medical Assistance in Dying

EVIDENCE

NUMBER 018

Tuesday, October 4, 2022



Co-Chairs:
The Honourable Marc GarneauThe Honourable Yonah Martin

Special Joint Committee on Medical Assistance in Dying

Tuesday, October 4, 2022

● (1830)

[*English*]

The Joint Chair (Hon. Yonah Martin (Senator, British Columbia, C)): I call the meeting to order.

Good evening, and welcome to the meeting of the Special Joint Committee on Medical Assistance in Dying.

I'd like to begin by welcoming the members of the committee and the witnesses, as well as those watching this meeting online. My name is Yonah Martin, and I am the Senate joint chair of the committee. I'm joined by Honourable Marc Garneau, the House of Commons joint chair.

Today we are continuing our examination of the statutory review of the provisions of the Criminal Code relating to medical assistance in dying and their application.

I'd like to remind members and witnesses to keep their microphones muted unless they are recognized by name by one of the joint chairs. When speaking, please speak slowly and clearly.

Interpretation in this video conference will work like an in-person committee meeting. You'll have the choice at the bottom of your screen of either floor, English, or French.

Again, I'd like to welcome our witnesses for panel one, who are here to discuss MAID when a mental disorder is the sole underlying medical condition.

By video conference, we have three panellists as individuals: Dr. Marie Nicolini; Shakir Rahim, lawyer at Kastner Lam LLP; and Dr. Michael Trew, clinical associate professor, University of Calgary. Thank you to all three of you for joining us.

We'll begin with remarks by Dr. Nicolini, followed by Mr. Rahim, and then Dr. Trew. Each of you will have five minutes, which I will be timing.

Dr. Nicolini, you have five minutes. The floor is yours.

Dr. Marie Nicolini (Senior Researcher, KU Leuven University and Georgetown University, As an Individual): Thank you and hello.

I'm Dr. Marie Nicolini, and I'm pleased to be here today talking to the committee.

I'm a medical doctor and a psychiatrist with a Ph.D. in bioethics. I was trained in Belgium, where the practice of MAID for mental disorders has been permitted for 20 years.

Over the last five years, I've published a wide range of groundbreaking research on MAID for mental disorders in top journals in ethics and psychiatry. I've performed this research at leading bioethics institutions around the world, including the National Institutes of Health and the Kennedy Institute of Ethics at Georgetown University, and I've delivered invited lectures on this topic at top universities, medical centres and conferences around the world, such as King's College London, the University of Pennsylvania, the American Psychiatric Association and the world psychiatry conference.

My research has established foundational facts about how the practice of MAID for mental disorders is actually carried out, based on large sets of data on actual cases of MAID in the Netherlands. In addition, my research has also clarified the ethical questions raised by the practice, particularly with regard to women. I have made it a point to pursue this research from a neutral perspective that sets out to examine how eligibility requirements apply, what the standards are for those requirements and what difficulties they raise. My research has not taken a position for or against the practice of MAID.

Based on these extensive and highly detailed investigations, I have discovered two central challenges for the practice of MAID for mental disorders. I'll say these two and then explain each one in a bit more detail.

First, incurability or irremediability is always a core requirement for MAID, but we do not have a coherent account of what it means for a mental disorder to be incurable. Second, countries that have MAID continue to pursue suicide prevention programs, but at this time there is no principle to guide clinicians in determining whether MAID or suicide prevention is warranted in any given case.

On the first concern, with MAID for cases of physical disease, there is always a requirement that the condition must be incurable or irremediable. In cases of MAID for mental disorder, that requirement carries over, but we do not have an understanding of what it amounts to for a mental disorder to be incurable. We can take an objective approach that lists all of the available evidence-based treatments and their likely prognoses, but my research shows that prognosis cannot be predicted in psychiatry. Alternatively, we could take a subjective approach, as Canada has, whereby patients themselves determine whether their mental disorders can be remedied, but this does not allow us to filter out cases in which MAID has been requested on the basis of social conditions or social maladies like poverty, unemployment, gender-based violence or other inequities.

On the second concern, because countries that have MAID for mental disorder do continue to pursue suicide prevention programs, it is of the utmost importance to establish clear parameters for deciding when we should assist with a wish for death and when we should take steps to prevent it. At this time, there is no practical or conceptual guidance that characterizes the difference between these two kinds of situations.

These two problems pose a serious ethical liability for any government that chooses to legalize the practice of MAID for mental disorder. If we don't have clear standards for what is curable and what is not and for the difference between MAID and suicide prevention, clinicians must proceed on a case-by-case basis in their evaluations around this ultimate decision. The problem with a case-by-case approach is that decision-making is then based on clinicians' personal intuitions and unrecognized biases.

My research has shown that patients with mental illness who also have physical disabilities are more likely to be referred to the End of Life Clinic in the Netherlands, now called the Expertisecentrum Euthanasie. Paradoxically, persons who also had physical disabilities were less likely to be seen by a psychiatrist before death was carried out. I think we can all agree that this is an outcome and a liability that Canada should set out to avoid.

Therefore, based on my research, it is highly problematic to allow MAID for mental disorders before we clarify first what it means for a mental disorder to be incurable, and second, what it is that distinguishes a case of MAID from a case of suicide prevention.

Thank you, and I look forward to your questions.

● (1835)

The Joint Chair (Hon. Yonah Martin): Thank you, Madam Nicolini.

Next we will have Mr. Shakir Rahim. You have the floor for five minutes.

Mr. Shakir Rahim (Lawyer, Kastner Lam LLP, As an Individual): Thank you, Chair.

By way of introduction, I'm a lawyer with a practice that includes human rights cases of provincial and national significance, including those that concern section 15, the equality provision of the charter.

I was intervenor and co-counsel in the case of Ontario v. G, a 2020 Supreme Court decision that applied section 15 in relation to mental disorder.

I am here today to offer my legal perspective, but I also note that I am a person who has lived with a mental illness for 18 years.

I will first explain how section 15 relates to MAID MD-SUMC, or mental disorder as the sole underlying medical condition. Second, I will discuss my view that the expert panel's recommendations comply with the spirit and letter of section 15 of the charter.

Subsection 15(1) confers the right to equal protection and benefit of the law. If a law makes a distinction in a discriminatory manner between persons on enumerated or analogous grounds, that is a subsection 15(1) violation. Mental disability is an enumerated ground.

A distinction is discriminatory if it imposes a burden or denies a benefit in a way that reinforces, perpetuates or exacerbates disadvantage. In the case law, the factors relevant to this determination are myriad and can include psychological or physical harm.

If Parliament passed legislation that created a separate MAID regime for those with a mental disorder and MAID was more difficult to access under that regime, that could violate subsection 15(1). This is because the regime would impose a burden on persons who seek to access MAID under the protected ground of mental disability.

However, section 1 of the charter permits a violation of subsection 15(1) if the state can establish it is within “reasonable limits... [that] can be demonstrably justified in a free and democratic society”. Whether this circumstance exists is assessed using the Oakes test: The state must have a compelling and substantial objective for the rights infringement, and the means chosen must possibly further that objective and interfere with the charter right as little as reasonably possible, and the benefits of the infringement must outweigh its negative effects.

In my view, the recommendation of the expert panel on MAID MD-SUMC conforms to the spirit and letter of the section 15 jurisprudence. I will highlight three reasons why.

First, the expert panel rejects the stereotype that those with mental disorders are the only group affected by concerns like incapacity, suicidality or the impact of structural vulnerabilities. The expert panel recommends that its safeguards, protocols and guidance apply to all clinical situations in which these and related concerns arise. The Supreme Court, in the case of G, emphasized how those with mental disorders lose their rights and freedoms specifically because of stereotyping about their propensities and capabilities. The expert panel's recommendation for a universally applicable approach precludes the application of that stereotype.

Second, flowing from the expert panel's observation about the universality of these concerns, it does not recommend a separate regime under the Criminal Code for MAID MD-SUMC. This approach reduces the risk of a subsection 15(1) violation, because there is no formal distinction made under the law in relation to mental disorder. To be clear, a distinction can also exist through the uneven application of a facially neutral law. However, a formal distinction would explicitly entail differential treatment and increase the risk of a subsection 15(1) violation.

Third, the expert panel endorses individualized forms of assessment. The panel emphasizes that case-by-case evaluations by MAID assessors of incurability, irreversibility and intolerability should be performed. This suggestion conforms to recent subsection 15(1) jurisprudence, which has recognized that an individualized assessment can be a less impairing alternative to a categorical form of treatment based on a prohibited ground of discrimination.

● (1840)

That concludes my opening statement. Thank you.

The Joint Chair (Hon. Yonah Martin): Lastly, we have Dr. Trew.

You have five minutes as well. Thank you.

Dr. Michael Trew (Clinical Associate Professor, University of Calgary, As an Individual): Thank you for inviting me to speak today.

With regard to a few words about my relevant background, I've been a clinical psychiatrist for 40 years in Calgary, with a special interest in the interplay between mental disorders and physical disorders. I am a clinical associate professor at the University of Calgary. I am the former chief medical officer of addiction and mental health at Alberta Health Services.

I chaired the Alberta Health Services non life-limiting expert panel from 2016 to 2018. I'm a member of the Canadian Psychiatric Association task group on MAID in mental disorders as the sole underlying medical condition. I am also a member of the Canadian Association of MAID Assessors and Providers, and I have provided psychiatric assessment primarily as it regards capacity in community settings.

In general terms, I respect and agree with the overall goals of Bill C-14 and Bill C-7,, along with the “Final Report of the Expert Panel on MAID and Mental Illness”.

In my view, mental disorders have long been seen as separate and distinct from physical disorders. I believe that any ongoing distinction between mental disorders and physical disorders in MAID-regulated legislation is unlikely to stand up to court review.

From my own clinical experience, I can describe cases that most people would agree represent appropriate use of MAID for people who have a mental disorder as their sole underlying medical condition. I can also report cases that most people would be very uncomfortable with if MAID for mental disorders were provided.

The challenge is to identify a reliable assessment system to make these determinations. Failure to generate such a system invites risks, including substantial variability from jurisdiction to jurisdiction, the risk of providing too much or too little MAID for mental disorders, the attendant ethical distress for providers and survivors, and MAID shopping.

In my view, the courts have judged on the most extreme cases, those with very strong and reasonable plaintiffs. These cases of extreme suffering and disability have established the principles that underlie MAID in general. Looking at them now, they seem relatively black and white, while some of the track two cases—and I anticipate many of the mental disorder as the sole underlying medical condition cases—will be very nuanced and grey in their details.

Not all of our requesters are or will be very reasonable. The level of complexity, combined with the current practice, which has emphasized for good reasons the independence of assessments, calls for some consideration of the processes and the expectations going forward.

The drive for MAID in the first place was largely driven by a person-centred, human rights-based approach. Bill C-14 largely focused on the question of not whether a person was going to die soon, but how and when they would die soon. I believe we have seen this taken up largely by individuals who are used to a high degree of personal control in their lives and choose to take this step at the time of their death. It has been very well received, and providers and survivors have attested to the relief and thanks that most would see as signs of success. The completion rate has been high in this group, once the formal request was made.

The anticipated situation for MAID with mental disorders being the sole underlying medical condition is very different. The Benelux experience reports a completion rate in the ranges of 0.5% to 4.5%, while our current overall Canadian completion rate in 2021 was reported to be 81%. This means an entirely different expectation is set for assessors, as well as providers, for those who request MAID for mental disorders.

● (1845)

I anticipate that this will be seen by some as being overly paternalistic. This may invite further court challenges unless the overlying administration is very carefully set and appropriate training is provided in concert across the country.

I appreciate the wording of the expert panel in describing shared decision-making. I believe we also need to build in the appropriate room for discussion between assessors after their first assessment in order to have the full opportunity to discuss these challenging cases. As noted above, while this is not explicitly banned in the legislation, the emphasis on independence of assessment leaves the impression that talking between assessors after their first meeting may not be acceptable.

I also appreciate the expert panel's recommendation for involvement of treatment teams as part of this expanded process.

I would recommend—

The Joint Chair (Hon. Yonah Martin): Sorry, Dr. Trew; would you wrap up shortly, please? Thank you.

Dr. Michael Trew: Sure.

I would recommend there be agreement on a waiting period after an application has been declined in order to avoid doctor shopping.

I'll stop there.

The Joint Chair (Hon. Yonah Martin): Thank you very much.

Thank you to our panellists.

We'll begin our first round of questions, led by Mr. Cooper. You have five minutes.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you, Madam Joint Chair.

Thank you to the witnesses.

I will direct my questions to Dr. Nicolini.

We have heard from some witnesses in the Netherlands that the number of cases that have been completed involving mental disorders is very small overall, amounting to 1.3% of cases. In expanding MAID in the Canadian context, it has been suggested, having regard for the experience in the Netherlands, that the pool of persons who would seek to access this, and would do so successfully, would be a very small number.

Could you speak to some of the differences between the legal framework in Canada versus the Netherlands with respect to safeguards, and specifically with respect to the irremediability requirement?

● (1850)

Dr. Marie Nicolini: Thank you for your question. I'll briefly respond to the numbers.

The number is correct. The number of MAID cases for mental disorders has been fluctuating both in the Netherlands and in Belgium. It's 1% to 2% of the total number of cases. It is important to note that when we talk about MAID for cancer, for example, we're talking about 10% of cancer patients who request MAID, so it's a substantial number.

As to the second part of your question, the differences between the framework in the Netherlands and Canada, I will just say the main difference is the way "irremediability", one of the key requirements, is being defined. The Netherlands adheres in their official guidelines to an objective account when they say that a clinician is supposed to assess a patient in light of their diagnosis and prognosis. My research has shown we cannot predict prognosis in psychiatry, so that account actually fails to function as a reliable account.

Canada explicitly endorses a subjective account. We have not started to determine what the standards would be for such accounts when we talk about mental disorders.

Mr. Michael Cooper: Would it be fair to say that it's not a fair comparison?

Dr. Marie Nicolini: I think that's right for that point, yes.

Mr. Michael Cooper: In your testimony you talked a little bit—and you just raised it again—about the issue of determining incurability. You also expressed concern or suggested it was problematic to assess cases on a case-by-case basis, as the expert panel recommended. The expert panel, on the question of incurability, spoke about determining it based upon "treatment attempts made up to that point, outcomes of those treatments, and severity and duration of illness, disease or disability." In other words, it's been said that someone who is suffering from a sole mental illness, who hasn't gone for treatments, who just shows up and requests MAID, is not the type of patient who would successfully obtain a request.

Can you speak to that recommendation of the expert panel and any concerns you see from that standpoint?

Dr. Marie Nicolini: Could you briefly clarify the last point?

Mr. Michael Cooper: I'm just saying—

Dr. Marie Nicolini: I want to make sure I understand.

Mr. Michael Cooper: I'm just trying to understand your thoughts, essentially, on the recommendations of the expert panel, which were that yes, these cases can be decided on a case-by-case basis, having regard for the diverse number of factors unique to each individual patient, but that regard would have to be for the number of treatments and the success or failure of those treatments before MAID could be carried out.

In other words, this would not be happening overnight. This would be happening over a long period of time of assessment, treatment, and so on.

● (1855)

The Joint Chair (Hon. Yonah Martin): Answer very briefly, Dr. Nicolini.

Dr. Marie Nicolini: Yes, of course. We all agree that evaluations themselves are done by clinicians very comprehensively and in good conscience.

The point about there not being standards is important, because if we do not have standards for what it means for a disease to be incurable, we cannot determine whether a patient meets that requirement.

The Joint Chair (Hon. Yonah Martin): Thank you, Dr. Nicolini.

Next we'll go to Mr. Maloney for five minutes.

Mr. James Maloney (Etobicoke—Lakeshore, Lib.): Thank you, Madam Chair.

Thanks to the witnesses for their presentations.

I'm going to start with you, Dr. Nicolini.

I arrived a moment or two after you started your presentation. I heard something you said and want to clarify it as a starting point.

You said, later on, that you cannot predict prognosis in a mental health context. Did I also hear you say that assessments would be based on the personal opinions and intuitions of the physicians making the assessment?

Dr. Marie Nicolini: I said it is a finding of my research, based on the best practice.

Mr. James Maloney: Is your view, then, that there are no circumstances for somebody who has a mental illness in which the prognosis can be that the condition is permanent? Is that right?

Dr. Marie Nicolini: That is right.

Mr. James Maloney: Okay, thank you.

Dr. Trew, do you agree with that position?

Dr. Michael Trew: I don't agree with that as a blanket condition, no.

Mr. James Maloney: Are you of the view that there are situations in which you can predict the prognosis for a patient who has experienced severe mental illness?

Dr. Michael Trew: Prediction is always a question of probability, and psychiatry is the same as the rest of life. I think there are certainly cases in which there's an extremely high rate of probability that this particular condition is not going to remediate.

Part of the struggle for everyone is.... What has also been discussed is the question of what new kinds of things are coming down the pike, whether it's ketamine or certain kinds of brain stimulation or whatever. That is the case for anybody who comes to a MAID panel.

Honestly, the best predictor of the future is the past. Someone who has attempted or gone across a wide range of treatments without response.... I think there's a point where we would take that as being a reasonable conclusion.

Mr. James Maloney: Okay, thank you.

That leads me to my next question. I want to pick up on something Mr. Cooper was touching on.

If I understood him correctly, he suggested there might be a risk that a patient who is experiencing mental illness and who has not undergone treatment could be allowed to access MAID. Is that a reasonable risk, in your opinion, Dr. Trew?

Dr. Michael Trew: I think the devil is always in the details. In this case, it's the details of what the arrangements are for assessment.

It shouldn't be the case that somebody who has not had reasonable trials can proceed with MAID—in my view, anyway. However, there is this issue of the legislation saying that if the treatment is not acceptable to the patient, you can't force them. I think there needs to be some clarification on a minimum amount of treatment before you can proceed to medically assisted death.

Mr. James Maloney: That's very fair and helpful, actually.

In your opinion—or Dr. Nicolini, for that matter—what's the likelihood of a doctor making a determination that MAID was appropriate for somebody who refused treatment who had not ever received any treatment? I would think it's somewhere between zero and unlikely.

● (1900)

Dr. Michael Trew: It's certainly unlikely.

Part of the difficulty is that historically, so much of the drive for medically assisted death has been based on individual human rights. Again, we're moving from a group of people who were likely to die soon, and everyone felt this was a reasonable thing to do for them, to a very different group for whom the probability of proceeding is actually low. Doctors, like everyone else, don't like saying no.

Mr. James Maloney: Thank you, Dr. Trew.

That's all my time. I appreciate it.

The Joint Chair (Hon. Yonah Martin): We'll now have Mr. Thériault for five minutes.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Thank you, Madam Chair.

I will address Dr. Nicolini first.

Dr. Nicolini, I very much enjoyed the text because, in my opinion, it raised some fundamental issues. However, I felt that your concerns were reflected within the expert panel's recommendations.

What are your thoughts on that?

[*English*]

Dr. Marie Nicolini: I will respond in English.

What I have stated is not a matter of personal opinion; they are my conclusions based on the extensive research that I have done. I had started researching this area when I was practising in Belgium and I decided to pursue neutral research on this topic. The conclusions that I bring today take a stance, but they are based on the neutral research that I've done before.

If there is time, I would like to respond to an earlier point about prognosis prediction in psychiatry, because I'm afraid I disagree—

[*Translation*]

Mr. Luc Thériault: I'm sorry to interrupt you, but I don't have much speaking time and I'd like to give the others a chance to ask questions.

That was my first question.

You've seen the panel's report that issues recommendations supporting a number of precautionary principles, particularly with respect to suicidality. It clearly states that the assessor could not receive a request for medical assistance in dying from a person in crisis. Individuals with mental disorders who are in a period of crisis would therefore be disqualified.

Here is a quote from the panel's final report:

> In any situation where suicidality is a concern, the clinician must adopt three complementary perspectives [when they become clear]: consider a person's capacity to give informed consent or refusal of care, determine whether suicide prevention interventions—including involuntary ones—should be activated, and offer other types of interventions which may be helpful to the person.

In this report, they were undeniably able to distinguish between people struggling with suicidality and recommendation 8.

I found the concept of consistency, which you mentioned, to be meaningful. In fact, I found it in the report.

Recommendation 8 states: “Assessors should ensure that the requester's wish for death is consistent...unambiguous and rationally considered during a period of stability, not during a period of crisis.”

The report also talks about durability over time. Multiple attempts are made.

Witnesses who have testified before the committee told us that, even in the case of so-called Track 2 or physical conditions, it's almost impossible to establish a clear and irremediable prognosis.

[*English*]

Dr. Marie Nicolini: To the point about prognosis, my research has shown.... We have actually, my co-authors and I, extensively looked at the question of prognosis prediction in psychiatry, looking at treatment-resistant depression as a paradigm case, looking both at clinicians' predictions and precision medicine. The conclusion is that we cannot predict prognosis. Contrary to what Dr. Trew was saying, the state-of-the-art science says that even when we use precision medicine, the best prognosis prediction in the long term is at the level of chance. That is what the science says. That is what has been published on this topic.

To the point about suicidality and autonomy that you're raising, I want to say this: Even if we agree, and we can, that some cases of persons with mental illness who have a wish to die warrant our compassion and assistance, we need to reckon with the fact that other cases of persons with a mental illness who want to die will warrant suicide prevention. No one believes that MAID should replace suicide prevention. The problem is that we don't have parameters to decide when to accept and when to reject patient autonomy on this.

It's helpful to clarify that when we talk about autonomy and if we want to be serious about autonomy, we talk about informed consent. The trouble is that many cases of patients who today receive suicide prevention meet the requirements for informed consent, so if we want to be serious about patient autonomy and if we want to legalize MAID for mental disorders, we first need to have a major overhaul of the way we do suicide prevention.

● (1905)

The Joint Chair (Hon. Yonah Martin): Thank you very much.

We now go to Mr. MacGregor for the next five minutes.

Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP): Thank you, Madam Co-Chair. Thank you to all of our witnesses for being with us today.

Dr. Nicolini, I'd like to start with you. I was taking notes during your opening statement and your remarks on the difficulties with establishing incurability and irremediability, and also the need for guidelines for suicide prevention, etc. I think no one would disagree with you on that.

With the way our Criminal Code is currently written, if you look at medical assistance in dying and the definition of a grievous and irremediable medical condition, you see that it does mention that it has to be a serious and incurable illness. It also does mention that there has to be an advanced state of irreversible decline. Paragraph 241.2(2)(c) also mentions that the condition has to be intolerable and also that it cannot be relieved under conditions that they consider acceptable.

There might be some potential conflict between those paragraphs because you may, hypothetically, come up with a treatment, but the patient may find that the treatment is not an acceptable one and may not believe that it can relieve their conditions properly. Do you have some thoughts?

I'm probably asking you the same question in a different form, but can you expand on that apparent conflict?

Dr. Marie Nicolini: Another way of saying what I've said before is that what's peculiar about mental disorders is that the staging models we have do not correlate with prognosis. When we talk about something incurable or irreversible, what we know is that someone can rate very high on that staging model, and that in no way correlates with long-term prognosis. That is another way to speak to the prognosis question.

Of course, it's not just a matter of prognosis and uncertainty, as I've said before. It's a matter of having adequate standards for what we call an incurable mental disorder. That is a whole different kind of issue we have in mental disorders that we do not have in physical disorders.

We do know, for example, what the standards for end-stage diabetes are. We may not know if someone.... For sure, there might be uncertainty about the prognosis, but we do have those standards about what we define as end-stage diabetes. We do not have that for mental disorders.

Mr. Alistair MacGregor: Thank you.

Mr. Rahim, I'd like to bring you into the conversation. I appreciate your opening remarks, particularly on section 15 of the charter, which states that everyone is deserving of equal protection and benefit of the law.

You've heard the conversation so far in this panel. You're well aware of the expert panel report that we have each read. If you look at the job that we as parliamentarians have on this committee and the recommendations we're going to be making to the federal government, is there anything in particular you would like to see included in that report, particularly with this thematic area of mental disorders as the sole underlying medical condition?

I know the expert panel felt that existing guardrails in the Criminal Code were adequate and that it was up to practitioners and the provinces and medical associations to develop these standards, but is there anything the federal government has not yet addressed appropriately in this area that you think this committee should be recommending?

● (1910)

Mr. Shakir Rahim: One thing that comes across to me, and it came across in some of the prior panel's proceedings, is the distinction between some terms in the code as being legal language versus medical language, and how that affects the clarity of understanding of what those terms mean and what they entail.

As a court or a lawyer, you're faced with a set of facts and a decision that has been made according to a particular legal standard, and you try to determine whether those facts fit into that standard. What I would take away from this discussion and the panel's deliberations is the importance of this committee recommending that there be, as much as possible, clarity and specificity in whatever is developed, whether at the provincial level or by regulatory bodies. This is with respect to standards on what constitutes something that is incurable, irreversible or what have you.

I think the expert panel's report goes a long way in setting that foundation. In my view, the deliberations here and in other committee meetings have illustrated that it's necessary to go further, if only to ensure that when courts are faced with trying to apply these legal standards to a particular set of facts and a particular approach taken by medical professionals, they also have some tools before them to assess that and aren't left in a situation de novo when they're trying to answer those questions.

The Joint Chair (Hon. Yonah Martin): Thank you very much, Mr. Rahim.

I'm going to turn this over now to my co-chair for questions from the senators.

The Joint Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)): Thank you, Senator Martin.

[*Translation*]

We will now turn to questions from the senators, starting with Senator Mégie.

Senator Mégie, you have the floor for three minutes.

Hon. Marie-Françoise Mégie (Senator, Quebec (Rougemont), ISG): Thank you, Mr. Chair.

My question is for Dr. Nicolini.

Dr. Nicolini, you stated earlier that the prognosis for an irremediable condition is based on probabilities. According to other experts who have appeared before this committee, only a small proportion of the total patient population would qualify. We're talking about people who have been ill for many years and have had many treatments, most of which have not been very effective.

What are your views on this? What do you think, not about the irremediable condition, but rather about the status of those patients?

In your opinion, could they meet the criteria required to receive MAiD?

[*English*]

Dr. Marie Nicolini: This goes to my point earlier.

I agree that a number of patients—in fact, many patients—will have a long history of prior psychiatric treatment. The question for individual MAID assessors is knowing whether or not they will truly not recover. That is what it means to meet the irremediability requirement.

When we look at the evidence in the literature and the trials that have looked at [*Technical difficulty—Editor*] with a set of patients who all meet those requirements of serious disease at the onset, and again, as I said earlier, that correlated in a way with their prognosis: The majority of these cases got better and a significant minority did not, so that is true.

The question is, how can we be sure? What kind of prognosis certainty do we have? As I said earlier, as things stand, we are close to chance level.

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you.

Mr. Rahim, I believe we spoke earlier about basic constitutional rights. You told us that denying MAiD for people with a mental disorder as their sole condition would violate section 15 of the Canadian Charter of Rights and Freedoms. That will likely happen.

What could we do or what could we include in the report to provide guidance and ensure that it doesn't happen?

● (1915)

[*English*]

Mr. Shakir Rahim: I think if the report included some specific consideration of the application of section 15 to the group of people who are seeking medical assistance in dying just on the basis of mental disorder and discussed—for example, drawing from some of the section 15 case law, such as the case in G—why an approach that either categorically excluded those living with mental disorder or applied a significantly more onerous regime upon them would raise equality concerns, that could go some way.

In my view, for the reasons I outlined in my remarks, I think that the expert panel's report has inherently incorporated those considerations in the way it has gone about thinking about the issue.

I know the panel report itself does not go into detail about how its recommendations conform to section 15, but things like the role of individualized assessment and the elaboration as to why the concerns raised are relevant for people with all medical conditions, not just those with mental disorder, are hallmarks of an approach that is ensuring that those with mental disorder are not stereotyped. It's a hallmark of an approach that takes into consideration the fact that categorical treatment that does not account for individual variance and difference in a group can ground, in part, a section 15 violation.

I think emphasizing those points would go some way to addressing that.

The Joint Chair (Hon. Marc Garneau): Thank you, Mr. Rahim.

We'll now go to Senator Kutcher for three minutes.

Hon. Stanley Kutcher (Senator, Nova Scotia, ISG): Thank you, Chair, and thank you to all our witnesses for helping us with this study. It's very much appreciated.

My first question is for Mr. Rahim.

Thank you for your thoughtful presentation. Also, I appreciated your sharing with us that you are an individual who suffers from a mental disorder. That gives you a perspective that many others may not have.

In the study of logic, there is something called an ecological fallacy, which is defined as the situation in which an individual who is a member of a group can be deduced by the criteria shared by the group they belong to. Thus, decisions made on the basis of group membership are fraught with challenge and problems, so a case-by-case basis is the way to deal with that ecological fallacy.

Do I understand you correctly that in Canadian jurisprudence, the courts have directed us to address MAID on a case-by-case basis?

Mr. Shakir Rahim: I would not go as far as saying that the court has created a direction specific to MAID that states that a legislative approach, when it comes to mental disorder or any other condition, must be on a case-by-case basis.

However, the section 15 jurisprudence recognizes that forms of treatment on an enumerated ground that are strictly categorical—for instance, all members of a particular group must be treated in this way because they have this characteristic or are at risk for particular vulnerabilities—may not pass constitutional muster.

To go back to my comments about the Oakes test and when a violation of section 15 (1) can be justified, there have been many cases that have recognized that a minimally impairing alternative—an alternative to saying that one group has to be treated in this particular fashion—is individualized or case-by-case assessment.

● (1920)

Hon. Stanley Kutcher: Thank you very much for that clarification. The importance is the case-by-case assessment, from what I understand of what you said.

Dr. Trew, I wonder if you could clarify this for me. I'm a bit confused. We heard that the Canadian perspective on decisions on irremediability is patient-driven and subjective.

As a practising psychiatrist and MAID provider, would you share that perspective or characterization that in Canada it's the patient who makes decisions about irremediability, or would you share the perspective that the panel talked about, which is that decision-making should be shared between physician and patient and it's the combination of sharing between physician and patient that's the key issue here?

The Joint Chair (Hon. Marc Garneau): Answer very briefly, Dr. Trew.

Dr. Michael Trew: Thank you.

I think I like the wording of the expert panel for sharing. I think that is a bit of a shift from how most people read Bill C-14.

The Joint Co-Chair (Hon. Marc Garneau): Thank you, Dr. Trew.

[*Translation*]

Senator Dalphond, you have the floor for three minutes.

Hon. Pierre Dalphond (Senator, Quebec (De Lorimier), PSG): My question is for Mr. Rahim.

[*English*]

In the G case, the Supreme Court said the case was going too far by a blanket exclusion and required some case-by-case analysis at least, to meet the test of hope, that there would be a safety valve, to a certain extent. The majority stated, and I quote: “Individual assessment does not need to perfectly predict risk — certainty cannot be the standard.”

Does that mean that some unpredictability with mental disorders, as with any other illnesses, does not invalidate, in the court's view, the perspective of case-by-case analysis?

Mr. Shakir Rahim: In my view, for example, in some of the section 15 jurisprudence that concerns when an infringement can be justified and what a less minimally infringing measure could be, the court has emphasized that the alternative need not be perfect—that looking for certainty when trying to establish an alternative that does not contravene section 15(1) is not the test.

To the extent that this would be responsive to your question, Senator, I would agree: That is not how an alternative that's less minimally impairing is evaluated. It is not a standard of perfection.

Hon. Pierre Dalphond: Thank you.

My next question is for Dr. Nicolini.

Doctor, I understand that you did not perform but studied assessments that could lead to MAID, but you have reviewed a lot of literature and research. You've said that 1% to 2% of the cases of MAID that are administered are related to mental illness, so that's a small percentage. Do you have numbers of how many requests were granted, the percentage of requests that were granted, and how many of those that were granted proceeded to completion?

Dr. Marie Nicolini: I want to clarify that I've not just reviewed the literature; I've actually studied a large sample of Dutch cases in which we looked at patient characteristics, their evaluations, how the requirements were applied and so on.

The Netherlands is the only country, as I'm sure you're aware, that publishes patient-level case reports. They publish the cases that have already been performed—people who have already died. That means we cannot compare those who have died versus those who have requested and been denied.

Hon. Pierre Dalphond: You have no data about how many that were requested were granted and, of those that were granted, how many decided to proceed at the end.

● (1925)

Dr. Marie Nicolini: These are not data that are published by the Dutch government.

Hon. Pierre Dalphond: So you have no idea about these things: You cannot say if there's a high level of people proceeding or a low level of people proceeding.

Dr. Marie Nicolini: We can say something based on the data of the end-of-life clinic, the Expertisecentrum Euthanasie, but that is not what the government publishes: In fact, it's a characteristic of the practice, a matter of practice, that we do not know how many get granted and how many get denied.

Hon. Pierre Dalphond: Thank you.

The Joint Chair (Hon. Marc Garneau): Thank you very much.

We'll now go to Senator Wallin for three minutes.

Hon. Pamela Wallin (Senator, Saskatchewan, CSG): Thank you very much.

I would like to hear from Dr. Trew and Mr. Rahim in response to a comment by Dr. Nicolini that we really don't have enough clarity on what the end stage of mental illness is, as we would in diabetes or cancer. I'm not 100% sure that I agree with that. I'm thinking that the end stage for far too many people is suicide, but I'd like the comparison to be clear.

If you have a cancer diagnosis and you don't want more treatment, yes, it's possible that a miracle might come along, a miracle cure, but you might choose to say, "No, I don't want that option. I don't want to live like this."

Why is it not the same, then, if treatment is not acceptable to you, with a mental disability that you've taken treatment for, but you don't want to wait for some miracle cure that might come along? Are those two situations not roughly the same?

Dr. Trew, if you would, please begin, and then we'll hear from Mr. Rahim.

Dr. Michael Trew: A couple of things cross my mind. One is that the statistics on death by suicide do not overlap terribly well with the statistics on chronic mental disorder—

Senator Pamela Wallin: Okay.

Dr. Michael Trew: —so men are three times more likely to die by suicide, whereas women are twice as likely to suffer from psychiatric illness. As an example, there is also a difference in the shape of the curve in terms of age.

I would very much agree with Dr. Nicolini that we need to work on our strategy for dealing with suicidality. There is still a lot of work to be done there.

I may have lost track.

Hon. Pamela Wallin: Yes, I am just trying to compare someone with a mental disability who is saying, "I'm at the end, I'm not waiting for the miracle", which a cancer patient might do as well.

Dr. Michael Trew: Sure. The issue then really does come down to how much is enough treatment.

If somebody has had really very little treatment from the perspective of an expert on a treatment that has a decent chance of making a difference, then we get really uncomfortable, yet if we're saying they have the right to say, "Well, I am not willing to try my third drug", what do we do?

That's the dilemma, because from our perspective, it looks like the right to refuse is sort of absolute.

Hon. Pamela Wallin: Do we have time for a quick comment from Mr. Rahim?

The Joint Chair (Hon. Marc Garneau): I'm afraid it will have to be very quick, Mr. Rahim.

Mr. Shakir Rahim: This underscores that what is incurable, or grievous and irremediable, is going to be subject to different interpretations.

When we think of incurability—and I'm thinking about the application of that as some kind of standard with respect to cancer—and we look at what has been proposed by the panel, this is precisely the type of clarity that the committee can bring in terms of what has to be developed to ensure that practitioners have the necessary information to make those conclusions.

Hon. Pamela Wallin: Thank you.

The Joint Chair (Hon. Marc Garneau): Thank you, Mr. Rahim.

We'll finish off with Senator Martin for three minutes.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Joint Chair.

My first questions are for Dr. Nicolini.

We've been talking about the differences between someone in track two with a physical illness or a mental disorder. The expert panel on MAID and mental illness concluded that its recommendations can be fulfilled without adding any new legislative safeguards to the Criminal Code.

Dr. Nicolini, do you agree that no additional Criminal Code safeguards are required in the case of MAID when the sole underlying condition is a mental disorder? Why, or why not?

● (1930)

Dr. Marie Nicolini: I disagree for the reason that I've said before. We need to recognize that we need different standards. We need standards in the case of mental disorders. We all agree that mental health is a distinct discipline. That's how we treat it in practice.

The distinction is important, because when we simply report the standards or the requirements for MAID for mental illness or mental disorders, we end up with a patchwork of safeguards, as we have in Belgium and the Netherlands. They do not truly capture the goals of MAID for mental disorders, or the safeguards that we all think are important.

The point is that the discussion about adequate safeguards can only start when we are clear about the adequate standards.

The Joint Chair (Hon. Yonah Martin): Are there specific safeguards we should be looking at? Are there any safeguards you want to mention at this time?

If not, with time, I have one quick question for Mr. Rahim.

Dr. Marie Nicolini: The safeguards are no substitute for a standard, so we first need to be clear on what the standards are before we can discuss the adequate safeguards.

The Joint Chair (Hon. Yonah Martin): Thank you for that.

Mr. Rahim, would it be a section 15 violation if the law prohibits MAID MD-SUMC because irremediability can't be determined based on scientific evidence, and not based on stereotyping or discrimination?

Mr. Shakir Rahim: Stereotyping is not a necessary component of the section 15 violation. Discrimination is defined as any imposition of a burden or denial of the benefit that reinforces, perpetuates, or exacerbates disadvantage. That is the test.

Deciding whether that prima facie violation of section 15(1) is then justifiable because there is some type of rationale—for example, the protection of people with mental disorders—is then done at the section 1 component of the Oakes test.

The Joint Chair (Hon. Yonah Martin): Is there specific evidence if that's the basis?

Mr. Shakir Rahim: Sorry; I didn't get the full question.

The Joint Chair (Hon. Yonah Martin): Am I out of time, Mr. Chair?

The Joint Chair (Hon. Marc Garneau): I'm afraid you are, Senator.

Thank you very much, Senator Martin.

It's back to you, Senator Martin.

The Joint Chair (Hon. Yonah Martin): Thank you, once again, to our panellists. You have given us much food for thought, and your expertise was very helpful.

We're going to suspend for a few minutes as we get the second panellists ready.

Thank you very much.

● (1930)

_____(Pause)_____

● (1935)

The Joint Chair (Hon. Yonah Martin): We're ready to resume, colleagues.

I have a few quick comments for the new panellists who have joined us.

Before speaking, please wait until I recognize you by name.

I will remind you that all comments should be addressed through the joint chairs.

When speaking, please speak slowly and clearly.

Interpretation in this video conference will work as it does in an in-person committee meeting. You have the choice, at the bottom of your screen, of either floor, English or French.

When you are not speaking, please kindly keep your microphone on mute.

As witnesses and by video conference, we have, as individuals, Mr. Mark Henick, mental health advocate, and Dr. Eric Kelleher, consultant liaison psychiatrist, Cork University Hospital.

Also by video conference, we have, from l'Ordre des psychologues du Québec, Dr. Christine Grou, president and psychologist, and Dr. Isabelle Marleau, psychologist and director of quality and practice development.

Thank you very much for joining us.

We're going to have our first presenter.

Mr. Mark Henick, you have five minutes. The floor is yours.

Mr. Mark Henick (Mental Health Advocate, As an Individual): Thank you very much for this time to express myself on such a vital matter.

First, I think most importantly what I'd like to say is that I come here as a person with lived expertise of a once treatment-resistant, long-term, major depressive disorder, comorbid with a social anxiety disorder and a history of multiple, escalating suicide attempts and in-patient hospitalizations.

For years I was prescribed cocktails of medications. I was restrained, isolated and written off as hopeless, yet, if not for who I was then, I wouldn't be who I am right now, and at long last I finally actually enjoy the freedom of loving myself for who I am right now.

Since those dark decades, I've pursued an advanced education, worked as a mental health counsellor and participated in some of the biggest mental health initiatives in the country. I've toured every province and territory in Canada to talk with survivors and their families about mental health and mental illness.

It's based on this experience, both professional and personal, that I vigorously oppose the expansion of medical assistance in dying solely for the reason of a mental illness. I can say without reservation that had MAID been available for mental illness and accessible to mature minors at the time, today I'd be dead. That wouldn't have been the only time in my life in which I would have considered it. I struggled with my mental health, at times severely, for more than 20 years, yet today I'm not dead. Today I'm actually better, but I'm not exceptional. Recovery is routine. We're resilient by nature, and it takes active oppression to keep us down. Unfortunately, oppression is pervasive. Recovery ought not to be a privilege afforded to the few who can afford it; recovery is a right. I'm evidence of what's possible when certain freedoms, choices and means are justifiably restricted.

I think this legislation has arisen from a dangerous reductionism. For example, mental illnesses and physical illnesses, which we heard about earlier, are not collapsible into one another. The elimination of this difference has been a misguided attempt to elevate the esteem of mental health through attaching it to the greater perceived esteem of more worthy physical health issues. This, of course, perpetuates stigma.

Mental health is worthy of independent esteem just as it is. The framing of mental illnesses as irremediable brain diseases is both unhelpful and largely untrue. Continually banging the drum of biological determinism, telling people that their brain is broken and irreparable, is not based in scientific consensus. This too perpetuates stigma.

Irremediability of mental illnesses cannot be reliably predicted. Any clinician who tells you otherwise, in my opinion, is simply not a very good clinician. If you've tried four medications without success and then you feel that nothing works and that you've tried everything, you haven't. You've tried one thing. Professional silos exhaust and kill people, and they too perpetuate stigma.

When allowing assessors to decide if someone with a mental illness is a hopeless case, you really need to ask yourself how many times you are willing to be wrong. How many wrongful deaths are acceptable? The absence of evidence for hope is not evidence for absence of hope.

If this legislation were actually about rights, it would more thoughtfully consider the decision pathway or the choice architecture that leads people with mental illnesses to want to die in the first place, whether through MAID or any other means. If you walk that path, you'd see that MAID for mental illness alone is actually indistinguishable from suicide. How can we make a free choice if we think we have no other choices available? This is what it's like inside the mind of somebody who is considering suicide. I would know. Thanks to our natural availability bias, exacerbated by the cognitive rigidity imposed by our mental duress and cultivated by the lack of accessible treatment options, we falsely conclude that we will never get better, that there's no hope, and we have no other choice.

It doesn't have to be this way. Recovery from mental illnesses is not only possible; it's indeed expected and likely, especially when people access care early, but every single province in this country is failing to meet its obligations under the Canada Health Act with respect to the delivery of mental health care. Until access to medically necessary psychotherapy is universal, and as long as wait times for psychiatry and other interventions can exceed a year or more, then mental health care in this country is neither accessible nor comprehensive.

MAID for mental illness alone essentially asserts that if people with a mental illness think they want to kill themselves, we should let them, and even help them to do so. To call this assisted dying is to sanitize the reality. This is assisted suicide, and that is in direct opposition to suicide prevention efforts.

● (1940)

MAID for mental illness alone is the ultimate indignity. It is worse than a violation of the rights of people with mental illnesses; it's robbing them of the opportunity to have their superseding rights restored and defended.

In the spirit of the law of this land and in the moral law of our hearts, mental health care is a right and suicide is not a crime. Suicide is a public health emergency maintained by a failing health care system. Don't pin that on the victims. Don't gaslight us into thinking that this is about our rights, our biological constitution or a romanticized ideal of a good death, one that happens to be conveniently cheaper on the public purse than investing in real care. The expansion of MAID to mental illness disincentivizes the repair of a broken system. Please refocus your energy instead on building a system that helps people to thrive, not to die. Every Canadian with a mental illness has the right to life, liberty and security of the person and the right not to be deprived thereof, whether that's by illness or systemic failings.

To that end, I ask you to fight for our charter right to live and stop the expansion of MAID for mental illness alone.

Thank you for your attention today.

The Joint Chair (Hon. Yonah Martin): Thank you very much.

Next we will have Dr. Eric Kelleher for five minutes.

Dr. Eric Kelleher (Consultant Liaison Psychiatrist, Cork University Hospital, As an Individual): Thank you.

I'll just begin by saying I absolutely echo and support everything my colleague Mr. Henick has just said.

My name is Dr. Eric Kelleher. I'm a consultant liaison psychiatrist working at Cork University Hospital, Ireland, and an honorary clinic senior lecturer at University College Cork. I'm a member of the College of Psychiatrists of Ireland, where I'm a vice-chair of the faculty of liaison psychiatry and a member of the human rights and ethics committee. I'm also co-author of our college's position paper on physician-assisted suicide and euthanasia, in which we oppose legislation to allow physician-assisted suicide and euthanasia in Ireland. One of our greatest concerns about this type of legislation is that such laws will be extended over time to include patients with mental illness, the position many patients with mental illness in Canada are now facing.

I'm speaking to you tonight, though, in a personal capacity. I thank the committee for their kind invitation.

I will summarize my opinion to three points.

My first is that in enacting this legislation, the Canadian government is sending a very clear message to patients with mental illness that not only is it acceptable to end your own life, but that the government will, in fact, help you to do so. This will forever damage not only the relationship that exists between mental health professionals and their patients but also how patients see themselves and their illnesses.

Being suicidal is a core part of diagnostic criteria for depression, some psychotic illnesses and certain personality disorders, all mental disorders that are eminently treatable with multidisciplinary team care.

Proponents of this legislation will tell you that there are distinct differences between a person who has a depressive illness who is suicidal and a person who has a depressive illness who is choosing MAID, when in reality it will be impossible for clinicians or assessors to distinguish between the two.

Mental illness, if any of you have been unlucky enough to experience it, does alter your view of yourself, your world and your future. The illnesses themselves generate hopelessness, lethargy, avoidance and non-compliance with treatment by their very nature. The integral part of what psychiatrists, psychologists and other mental health professions do is to identify and treat mental illness, restore hope and support the patient at some of the most difficult times of their life. How can mental health professionals and Canadian suicide prevention strategists say to patients with mental illness that we encourage you not to end your life when MAID for mental illness would allow you to do so?

This brings me to my second point.

It is the duty of the Canadian government, and the government in Ireland or indeed anywhere in the world, to protect its most vulnerable citizens and ensure that legislation does not cause harm. Those who develop mental illness such as depression and suicidal thoughts are more likely to be poor, uneducated and disenfranchised and to have experienced childhood trauma, including sexual abuse.

In the Netherlands, 60% of patients who received euthanasia were described as lonely and socially isolated. Research shows that women are more likely to experience clinical depression and experience abuse, and are also more likely than men to access MAID for mental illness——

● (1945)

The Joint Chair (Hon. Yonah Martin): I'm sorry, Dr. Kelleher. I'm sorry for the interruption.

Would you slow down the rest of your presentation? We have translation in both languages. Thank you very much.

Dr. Eric Kelleher: No problem.

Rather than enabling patients to end their lives through assisted suicide, governments should consider how much funding there is for mental illness, how long the waiting lists are to see a psychiatrist and how government can provide excellent multidisciplinary team care to such patients. Only then can patients truly be said to have a choice about their treatment.

This brings me to my third point. The management of mental illness involves seeing the patient as a whole person and exploring all aspects of their presentation and their care—the psychological, social and biological factors. There is no evidence that mental illness treatment is irremediable. In practice, improving some or indeed all of their biological, social and psychological factors may need to be optimized for a patient to see an improvement.

Do you consider a suicidal patient who is suffering from a clinical depression associated with significant loneliness and poverty to be irremediable? Of course not, but many of these factors, such as poverty and housing, may take months to address adequately, by which time they may have already died from MAID in mental illness if provided.

I was shocked to read how a patient in Canada with multiple chemical sensitivities was provided with MAID because they could not cope living with their illness in housing that did not meet their health care needs, despite official agencies looking for such housing for two years. Surely there was something profoundly wrong about this woman's treatment that she could secure death from government-funded agencies but not housing.

In summary, disclosing difficult and frightening thoughts like suicide needs to be met with not only empathy but also practicality, working with the patient to find solutions. It's not to superficially endorse their dangerous and life-threatening cognitive distortions of mental illness and enable patients with mental illness, some of society's most vulnerable, to end their own lives by providing MAID for mental illness.

I sincerely thank you for your attention. I would be happy to answer any questions.

Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you very much.

Dr. Grou and Dr. Marleau, are you both speaking, or...?

Okay. I assume that Dr. Grou will be speaking. Thank you very much.

Dr. Grou, you have the floor for five minutes.

[*Translation*]

Dr. Christine Grou (President and Psychologist, Ordre des psychologues du Québec): First of all, I would like to sincerely thank the Special Joint Committee on Medical Assistance in Dying for inviting me to appear before you.

My colleague and I represent the Ordre des psychologues du Québec, of which I am president.

I am a clinical psychologist and neuropsychologist specializing in mental health. I've been treating people for 35 years. I've worked 30 years in a hospital setting and 25 years in the psychiatric setting. I have naturally acquired expertise in neuropsychology with respect to severe mental disorders, and also ethics expertise. So I'm an ethicist, and I chaired the hospital's ethics committee for over 10 years to discuss complex cases.

Dr. Marleau, who specializes in neurodevelopmental disorders, also worked for 15 years in the public health system as a clinical psychologist.

Medical assistance in dying is a subject that has motivated us from the outset at the Ordre des psychologues du Québec. MAiD for people with mental disorders is also of particular concern to us, given our expertise.

First and foremost, I would like to say that the Ordre agrees with all the expert panel's recommendations, but to start with, I must also say that we and the Ordre are strong believers in treatment and recovery.

We have chosen restorative professions. We've chosen to treat people, and the Ordre des psychologues du Québec ensures the quality of psychological services and development of practices, as well as access to services. Therefore, we strongly believe in treating people suffering from psychological distress and mental disorders.

I'd like to reiterate, as does the panel, that we prefer the term “mental disorder” over “mental illness”, which is already used in medical literature. We believe that it's not necessary to add additional criteria or guidelines to make people with mental disorders eligible for MAiD. That said, the guidelines should be very well understood and very well operationalized.

Right now, most people who request MAiD do so because of their physical condition. However, they have the right to do so, not because their physical suffering isn't being alleviated, but because their physical condition is causing them unalleviated psychological suffering. Why apply a different rationale to people who suffer solely from mental disorders? As with physical conditions, we believe that the current assessment process is sufficient to ensure that MAiD requests are made freely, in an informed, consistent and well considered manner. Of course, the challenge lies in confirming that the condition is a mental disorder of an irreversible nature and that the suffering is enduring and intolerable.

In our view, the current criteria will disqualify cases in which suicidality would be related to a spontaneous desire for death brought on by a crisis or by an untreated or inadequately treated disorder. We're confident that the assessment process will respect the autonomy of individuals with a mental disorder while also protecting individuals who are vulnerable due to their condition or because they are having trouble gaining access to services.

With respect to assessing MAiD, we believe that psychologists and neuropsychologists should be brought into the process given their particular expertise, and that they could provide considerable input. We even believe they could be designated as independent expert assessors.

We believe that, based on the nature of the issue and the context, it might be more appropriate to call upon them. I would add that psychologists and neuropsychologists have eight to nine years of academic training. In addition, they are particularly knowledgeable about the narrative space that is conducive to confiding and, most importantly, they are trained to take a neutral position when it comes to the patient's subjectivity. They are also trained to neutralize their own feelings.

In terms of implementation, it stands to reason that professional training should be tailored to include mental disorders. The same thing goes for MAiD guidelines and standards of practice.

So far, the way has been well paved and monitored for MAiD. The established guidelines should help prevent potential abuses.

● (1950)

We also believe that the existing guidelines will ensure that a very small number of people are eligible for MAiD. The guidelines are already in place. Now we need to properly operationalize the safeguards.

In my opinion, the community needs to take this step. It's taken a long time to recognize the rights and autonomy of people with mental disorders. It's also taken a long time to recognize the individual, to not distinguish between the two types of health and to recognize overall health. There's no clear-cut distinction between mental health and physical health.

Now that people recognize the rights and autonomy of people with mental disorders, we shouldn't deny them a right that we give to all other patients. Furthermore, we shouldn't be tempted to pit access to services and quality of services against MAiD. On the contrary, I believe that access to services and quality of services must be guaranteed before considering MAiD.

We'd be happy to answer your questions and take part in the discussion.

● (1955)

[*English*]

The Joint Chair (Hon. Yonah Martin): Thank you to all of our panellists for your testimony today.

We're going to go to our first questioners. Madame Vien and Mr. Cooper will share their five minutes.

We'll begin with Madame Vien.

[*Translation*]

Mrs. Dominique Vien (Bellechasse—Les Etchemins—Lévis, CPC): Thank you very much, Madam Chair.

My questions are primarily for Dr. Grou.

Dr. Grou, I read your brief and I found it fascinating. Recommendation 7 states:

> Refusing a medication or refusing any other treatment should never disqualify someone who wishes to receive MAiD.

What would you say about someone who refuses treatment or has not gone through all available treatments when mental disorder is the sole reason for a MAiD request?

Dr. Christine Grou: Actually, what we need to assess and what we need to avoid is therapeutic overkill, on the one hand. On the other, when we offer mental health care, we want free and informed consent, just as we would for any treatment. For consent to be free and informed, the person must be advised of the nature of the proposed treatment. The person must be informed of the benefits, potential consequences and possible harms that come with the treatment, and alternative treatments must be offered. The person's informed choice should be respected.

In other words, as long as the person has the cognitive autonomy to make a decision, fully understand the information and make a judgment, we will respect their choice. For example, a person may refuse—

Mrs. Dominique Vien: Dr. Grou, I would ask that you wrap it up quickly, because I don't have much time left and I'd like to ask you one more quick question.

Dr. Christine Grou: If we respect the person's informed consent, that means we cannot force them to accept all care. Otherwise, it's tantamount to saying that we no longer respect their consent.

Mrs. Dominique Vien: In your opinion, these individuals need to have access to psychotherapy, and yet the availability of services varies greatly, especially in a rural region like the one I represent.

What can you tell us about that?

You say that governments need to acknowledge that.

Dr. Christine Grou: What I'm saying is that the MAiD request should not be seen as a failure of the health care system.

When proposing health interventions, one must first have taken history of past interventions done with the person. Prognosis is hard to establish, yes, but it is possible to do it when a person has a long history of mental disorders. So we need to design services to keep people from requesting MAiD out of spite.

We mustn't pit quality of services and access to services against MAiD. We really need to ensure one and enable the other, and not pit them against each other.

Mrs. Dominique Vien: Thank you.

[*English*]

The Joint Chair (Hon. Yonah Martin): Thank you.

Mr. Cooper, you have the remaining two and a half minutes.

Mr. Michael Cooper: Thank you, Madam Co-Chair.

Dr. Kelleher, some witnesses have warned this committee about suicide contagion, noting that in countries that allow MAID for mental illness, suicide rates have increased. Other witnesses have disputed those claims.

Based upon your research, what happens to suicide rates in countries that allow MAID for mental disorders?

Dr. Eric Kelleher: It's a really, really good question.

Unfortunately, there isn't a whole lot of information out there. A recent systematic review, one of the highest forms of evidence, was published this year. It said just that: that there isn't a lot of research in this field.

Several studies do report increases in the overall rates of self-initiated death, and in some cases increases in non-assisted suicide in countries that have brought in MAID-type procedures. In particular, women in some of the Benelux countries are increasingly accessing MAID for mental illness. That's a pattern. Typically, women who engage in self-harm choose non-lethal methods to do so. However, there's been a rising number of women with psychiatric illnesses dying from MAID provision for mental illness, which is in contrast to what we see in men.

Certainly some of the trends from Europe are that MAID for mental illness seems to disproportionately affect women, and in some countries it appears to also have a contagion effect in increasing the non-assisted suicide rate. That's something we see in suicide research anyway: There's also a contagion effect when there are suicides locally, and that's why we have very strict media guidelines and reporting about suicide and how it is portrayed in the media.

● (2000)

Mr. Michael Cooper: Thank you.

Dr. Kelleher, could you provide the studies you have referenced to the committee?

Dr. Eric Kelleher: I can, absolutely. They were both published earlier this year. One is by David Jones, who's in the U.K., and another is by Professor Anne Doherty, who's in Dublin. I can send you those references, yes.

Mr. Michael Cooper: Thank you.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Cooper.

Next we have Monsieur Arseneault for five minutes.

[*Translation*]

Mr. René Arseneault (Madawaska—Restigouche, Lib.): Thank you, Madam Chair.

My first question is for Mark Henick.

Mr. Henick, thank you for sharing your personal experience and that you overcame mental illness, if I may say so.

Before the end your presentation, you said that if you had not fought your illness, you would have been a victim of MAiD.

Did I understand your testimony correctly?

[*English*]

The Joint Chair (Hon. Yonah Martin): The translation is quite delayed.

Which witness did you...?

Mr. René Arseneault: It's Mr. Henick.

Mr. Mark Henick: I've never applied for medically assisted death.

[*Translation*]

Mr. René Arseneault: You never requested MAiD, but I thought I heard you say that, had it been an option at the time, you would have requested it.

Is that what you said?

[*English*]

Mr. Mark Henick: Yes, that's correct.

Had it been available during the peak of my struggles, and in fact throughout the duration of my chronic mental illness, there were many times when I would have applied.

[*Translation*]

Mr. René Arseneault: You never requested MAiD, and you never consulted any assessors to make a request.

Is that right?

[*English*]

Mr. Mark Henick: No. It wasn't available.

[*Translation*]

Mr. René Arseneault: Thank you.

Dr. Grou, if I understood your testimony correctly, you agree with all of the recommendations in the expert panel report.

We often get stuck on the irremediable nature of mental disorders.

Do you have anything to say in connection with that and the recommendations in the expert panel report?

Dr. Christine Grou: It is true that it's more complicated to make a prognosis for mental health. That said, it's complicated for some physical conditions too.

Should this apparent complexity lead to the denial of MAiD requests, or should it lead to further consideration of the issue to define better guidelines?

I feel that better guidelines should be developed.

Mr. René Arseneault: Can you give us any leads in that respect?

Dr. Christine Grou: I will give you a very concrete example.

In 25 years of psychiatry and 30 years in a hospital setting, I've seen two cases where patients could have requested MAiD and might have succeeded in getting it. Given the current guidelines, it's impossible to get it at age 20 or 25. Moreover, a patient cannot get it during an untreated episode of major depression or if they don't have a long history of pain and suffering.

If a patient has been suffering for 10 or 15 years despite treatments that an independent expert considers to be relatively optimal, and if therapeutic trials are conducted and, for any number of reasons, a dark cloud still hangs over the patient's head, MAiD might be an option.

It's important to understand that some people have lived extremely hard lives and it can be extremely complex to treat certain health issues. If I say to you that someone has cancer of the soul and and it's untreatable, would you say we should condemn them to a life of suffering? Should they be deprived of that freedom to choose?

I would tend to say you have to take into account the desire for death in someone who is not capable of living and has tried everything. We're not talking about someone who's been abandoned by the health care system. We can look at the nature of the treatment, the longevity of the treatment, the intensity of the suffering and, most importantly, the duration of the suffering, including all the health conditions the patient suffers from.

You also need to consider agreement from the person and their entourage, their family, who have watched them live for 10, 15 or 20 years. In that context, do you truly risk being wrong about the prognosis? I don't think so.

● (2005)

Mr. René Arseneault: Thank you.

My next question is for Dr. Kelleher.

Dr. Kelleher, has the research and findings you've shared with us today been put into the context of the Carter decision by the Supreme Court of Canada?

I would like to point out that the Carter case, unanimously, guided us in medical assistance in dying based on section 7 of the Canadian Charter of Rights and Freedoms. This section speaks to the right to life, liberty and security of the person.

[*English*]

The Joint Chair (Hon. Yonah Martin): Be very brief, Dr. Kelleher.

Dr. Eric Kelleher: Can he clarify the question, please? I didn't hear the question clearly.

The Joint Chair (Hon. Yonah Martin): My apologies, but we have run out of time on this one.

[*Translation*]

Mr. René Arseneault: Thank you.

We can move on to the next person.

[*English*]

The Joint Chair (Hon. Yonah Martin): We'll move to the next questioner, Monsieur Thériault.

[*Translation*]

Mr. Luc Thériault: Thank you very much, Madam Chair.

I have the following question for you, Mr. Henick, because your testimony was based on your personal experience. You also heard Dr. Grou's testimony.

If you have read the panel's report, what makes you think you would have been eligible for medical assistance in dying when you were not well?

You look very young—younger than I look at least. What makes you think you would have had access?

[*English*]

Mr. Mark Henick: Thank you for that question and the opportunity to follow up on that.

I am convinced that I would have been an eligible candidate. I had been in and out of hospital involuntarily more than half a dozen times. I had been transferred to different hospitals. I was on locked wards. I was on more than a dozen different medications, and nothing really seemed to work. I talked to plenty of different doctors. It was chronic and persistent for enough years that I absolutely would have been a candidate, and should this legislation have continued to unfold toward allowing so-called mature minors, I would probably have qualified much earlier on.

I am so grateful, so eternally grateful, that MAID for mental illness was not available when I was struggling, because I was convinced that I wouldn't live to see another day, and I have. I think everybody deserves that opportunity too. If you really look at the root causes of why people are struggling for so long, it's not that the treatments don't work. We have lots of evidence to suggest that they do and that the real problem is access and getting connected to those treatments, which was exactly what I experienced.

[*Translation*]

Mr. Luc Thériault: Thank you very much, Mr. Henick. You've answered the question. I'm sorry for interrupting you.

Since I don't have much time, I'll now turn to Dr. Grou.

Dr. Grou, you've read the report as well. You've told us that you support it.

If we were to move in the direction of allowing requests for medical assistance in dying from people with mentally illness when that would be the only medical reason given, how could that be considered an impediment to suicide prevention?

Dr. Christine Grou: Suicide prevention is an important area to continue to work on, including providing access to care and continuity of care. There is clearly a ways to go in this regard.

However, suicidal patients shouldn't all be lumped together. For suicidal patients where this is an expression of the moment, an impulsive expression, and who are doing better two weeks later, we should continue to treat them and do prevention work.

The situation is very different in the case of a person who has a physical health problem, who no longer has any quality of life and who becomes suicidal in a thoughtful and reasoned way. In that case, we will consider medical assistance in dying.

Take someone who has a mental health problem that they can't break free of, who can't get better, and who has suffered intolerably for a long time. That person could also, in a thoughtful and rational way, prioritize the quality of their life over the sanctity of life and have a desire for death. This suicidal person, who wants to die, is therefore more like a person who might apply for medical assistance in dying and may be the one to do so. Not all suicidal people are the same, and not all motivations and suicides are the same.

If you're talking about someone who has thought long and hard, who has been offered treatment, and even different treatment options, who has a treatment program that hasn't worked, who wants to stop suffering, and who is contemplating death, there are two choices. I can assure you that there are patients who are going to take their lives anyway in a context like that and in a thoughtful way. Would we rather force them to die alone, in conditions that are sometimes risky, or would we rather allow them this care, which is offered to any other patient, so they can have a more supported, more dignified and safer death?

In both cases, perhaps we should give these patients access to medical assistance in dying. If we don't, isn't that denying them a fundamental right and, again, taking a step backwards in mental health by saying that we're going to respect the autonomy of all patients in their choice of treatment, in their desire to be treated or not, and even in taking responsibility for their treatment? Isn't that saying that we will respect their autonomy for everything, but not for their request for medical assistance in dying, and that we will exclude them once again? This sets mental health and the rights of mental health patients back by half a century.

● (2010)

[*English*]

The Joint Chair (Hon. Yonah Martin): *Merci*.

Mr. MacGregor, the floor is yours for five minutes.

Mr. Alistair MacGregor: Thank you, Madam Co-Chair.

Thank you to the panellists for being with us today.

Mr. Henick, I'd like to start with you. I appreciate your coming before our committee and sharing your personal story.

Ultimately, what was the treatment that led to your success and where you are today? I'd like to know a little bit more about the medical professional who was involved in helping you with where you are today and about the treatment that made your personal story a successful one.

Mr. Mark Henick: I wish I could tell you that it was something more eloquent than luck and time, because some of the treatments I received made me a lot worse. There is a well-known warning on prescribing antidepressants to kids—now if they're under 30, but especially if they're just teenagers, as I was. I was on more than a dozen different antidepressants, antipsychotics, anxiolytics, sleeping pills, hypnotics, anti-seizure medications prescribed off-label for various reasons, and a number of others.

In some ways my treatment actually hindered my recovery. What I experienced with my in-patient hospitalizations was largely traumatic.

It was only after I was able to go off to college, get a better social support network and start getting into therapy.... I had never had access to psychotherapy in a meaningful way when I was in the acute valley of my struggle. It was only through that kind of social support, time and doing something different with my life that I was able to see that I was capable of so much more than I thought before.

Mr. Alistair MacGregor: I'm sorry to interrupt, but I have limited time and I have a few more questions for you today.

You did state that had medical assistance in dying for a mental disorder as a sole underlying medical condition been available, you would have applied for it. Can you say with certainty, given the guardrails that exist in our Criminal Code, that...? You need those two independent medical practitioners.

It seems to me it's a hypothetical here. You're saying with certainty that it would have been granted, but we can't truly know that for sure, can we?

Mr. Mark Henick: Well, you yourself can't, but you learn, when you've been an in-patient in a hospital enough times, what to tell doctors in order to get them to do what you need them to do. I was able to get out of hospital when I shouldn't have been. I was able to get into hospital when I shouldn't have been, perhaps. When you're a “frequent flyer”, as I was frequently called, you learn how the system works.

I saw that as a mental health professional, as well. Patients do that all the time.

● (2015)

Mr. Alistair MacGregor: I want to clarify.

For medical assistance in dying for people suffering from physical ailments causing them grievous and irremediable harm, and they're going through that suffering.... Are you in support of that for physical ailments?

Mr. Mark Henick: Like [*Inaudible—Editor*].

Mr. Alistair MacGregor: Are you in support of it for someone who has terminal cancer?

Mr. Mark Henick: Sure. I don't have a blanket opposition to medical assistance in dying, no. I think it's a false comparison between the two, however.

Mr. Alistair MacGregor: I want to dig down on that, because we've had previous witnesses talk about the section 15 rights to equality before and under the law. We know the view the Supreme Court has taken on these things. The fact of the matter is that the law has already been changed. We're looking at this after the fact.

I'm saying this with respect, really. It's a truthful question. How do you reconcile your view with someone's section 15 rights? What if there were someone with a mental disorder who had a completely polar opposite view to yours? Are you saying that your view should override their personal story and subjective experience? I truly want to dig down into your viewpoint on that.

Mr. Mark Henick: I'm saying that the treatment pathway for each of those conditions is very different. Chances are somebody who has end-stage cancer—as a previous witness mentioned—has a much clearer picture that that their condition is indeed irremediable and that they are indeed going to die anyway or in the foreseeable future, even though that part is different now. They likely didn't experience the same kind and degree of stigma, discrimination and failure of social supports that somebody with a mental health problem or illness did.

I can absolutely defend treating them equally in isolation, because the contexts that lead people to that point are very different.

There's also the added piece that mental illness will, by definition—even if you don't lose decision-making capacity—inform the decisions you make. We can't ignore that context.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. MacGregor.

I will now turn this over to Monsieur Garneau, my joint chair.

Thank you very much.

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Martin.

We'll go to the senator round of questions for three minutes each. We'll have to stick to those three minutes.

[*Translation*]

We'll start with Senator Mégie.

Hon. Marie-Françoise Mégie: Thank you very much, Mr. Chair.

I'd also like to thank the witnesses for being with us.

My question is for Dr. Grou.

Dr. Grou, you said that you agreed with the idea of not including new guidelines for people whose mental disorder is the sole reason for requesting MAID. You also said that the same guidelines can be used, but they must be properly managed.

Do you have an example of a shift that might have occurred with respect to the guidelines?

I'll ask you a second question right away because I only have three minutes. This will let you organize your answers accordingly.

What could you suggest from a regulatory perspective to guide MAID assessors in the case of individuals with a mental disorder?

Dr. Christine Grou: As far as the guidelines are concerned, in fact, the Quebec Commission spéciale sur l’évolution de la Loi concernant les soins de fin de vie believes that the guidelines are adequate, if they are properly interpreted. In terms of operationalization, we have made a series of recommendations because that's where a lot of work needs to be done.

However, there is no doubt that great care must be taken when assessing the patient's personal history, particularly when assessing the likely irreversibility of the mental disorder. It is extremely important to take the time to do this, with the patient and with the family. A history of treatment, outcomes and periods of remission should be taken. For example, it should be determined how long the remissions lasted.

It's necessary to try to establish a kind of pain pathway or pain intensity, even if it's subjective. It's important to be able to estimate the intensity and permanence of the suffering experienced. The other thing that is absolutely fundamental is to ensure, as a society, that there is access to services and that access does not vary from region to region. We must also ensure the quality of services.

The guidelines provide for the services of competent professionals who will inform the person not only of their health problems—because they are often multiple—but also of the treatment options that are available.

The process also includes a reflection period. Consent is a process. In mental health, we have the time to do things properly. We have to look at all the guidelines. Competent professionals must be called upon to provide a proper assessment.

Since ambivalent patients aren't eligible, care must also be taken to ensure that the person's decision is persistent and consistent with their values. A desire for death must not be an expression of the disease or of one of its recurrences.

● (2020)

The Joint Chair (Hon. Marc Garneau): Thank you very much, Dr. Grou.

We'll now go to Senator Kutcher.

[*English*]

Hon. Stanley Kutcher: Thank you very much, Chair.

Thank you to all the witnesses for helping us in these challenging deliberations.

My questions are for Dr. Kelleher. There will be three or four of them, but they require only very short answers.

You're here as a person with expert opinions about MAID. In your testimony, you alluded to a case in Canada.

The first question is this: Are you qualified as a MAID assessor and provider in Canada or in any other country?

Dr. Eric Kelleher: No, and in Ireland—

Hon. Stanley Kutcher: That's great. That's fine.

The other question is, how many MAID assessments have you participated in or seen or viewed or sat in on in Canada?

Dr. Eric Kelleher: I work in Ireland. I don't work in Canada.

Hon. Stanley Kutcher: That's okay. I know where you work. Thanks.

Dr. Eric Kelleher: I haven't done any MAID assessments. I'm not qualified and that's not something I—

Hon. Stanley Kutcher: Okay. Do you know the protocol used for MAID in Canada, and specifically what medication they use, what doses, in what sequence and what the route of administration is?

Dr. Eric Kelleher: I have read up on that and I do understand some of the issues around that, yes.

Hon. Stanley Kutcher: Can you tell me, then, what the doses are and what medications are used, and in what sequence?

Dr. Eric Kelleher: I don't know what the doses are, but they're usually some barbitones.

Hon. Stanley Kutcher: Do you know of any Canadian data on the process of MAID provision and what happens to a person in the process of receiving MAID? Are you familiar with that data?

Dr. Eric Kelleher: I have read the protocol, but my concern about—

Hon. Stanley Kutcher: Given all those things, in your—

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): I have a point of order, Mr. Chair.

Hon. Stanley Kutcher: —report you state:

> techniques used to bring about death can themselves [result] in considerable and protracted suffering.

The Joint Chair (Hon. Marc Garneau): One moment please, Senator Kutcher.

Go ahead on your point of order, Mr. Barrett.

Mr. Michael Barrett: Thanks, Mr. Chair.

I'm just wondering if the practice at this committee is similar to that in other committees whereby witnesses are given an amount of time to answer the question that is equal to the amount of time required to pose the question. I appreciate that time is limited, but this is not typically a committee where expert witnesses can give yes-or-no answers to questions.

The Joint Chair (Hon. Marc Garneau): I believe that's argumentative. No, there is no rule about equal time for questions and answers. There are specific questions, and in some cases, the questioner is allowed to move on to the next question.

Please carry on, Senator Kutcher.

Hon. Stanley Kutcher: In your report, you write:

> techniques used to bring about death can themselves [result] in considerable and protracted suffering.

Can you tell us on what information, in the Canadian context, you are basing the statement that someone who is receiving MAID will actually, because of MAID, have “considerable and protracted suffering”?

Dr. Eric Kelleher: Can I ask exactly what you're quoting from?

Hon. Stanley Kutcher: The quote is from this document that was provided to us.

Dr. Eric Kelleher: I'm so sorry. What exactly are you quoting me from? I don't recognize what you just held up there.

Hon. Stanley Kutcher: We all have a copy of this. It's a position paper on physician-assisted suicide and euthanasia from the College of Psychiatrists of Ireland. It says, "Consultant Liaison Psychiatrist Dr Eric Kelleher...Speaking today, he said..."

Dr. Eric Kelleher: What we are concerned about—and this was in our college's position paper—is that in Ireland—again, this echoes other speakers who have spoken before—access to palliative care is limited throughout the country. We do not have immediate access to things like hospices and the provision of palliative care, as I said.

What I do as a liaison psychiatrist, working co-jointly with our colleagues in palliative care.... Providing mental health care to patients with mental illness isn't easily available in different parts of the country. Having access to all treatment alleviates distress for somebody who has a terminal illness and who is dying. It's something that we, as the college, believe should be easily provided for.

It isn't something that is available. That's what our concerns were.

● (2025)

The Joint Chair (Hon. Marc Garneau): Thank you, Dr. Kelleher.

We'll now go to Senator Dalphond.

[*Translation*]

Hon. Pierre Dalphond: Thank you, Mr. Chair.

My question will be for Dr. Grou and perhaps also Dr. Marleau.

Brian Mishara, a professor at the Université du Québec à Montréal and director of the Centre de recherche et d'intervention sur le suicide, enjeux éthiques et pratiques de fin de vie, has studied the practice in the Netherlands. He concluded that the average assessment of a person requesting medical assistance in dying for mental health reasons took 10 months—a fairly lengthy process—and that only 5% of requests were granted.

Dr. Grou, from what I heard earlier, in 30 years you've seen two cases that met the criteria suggested by the special committee that recommended guidelines.

In your experience as a clinical psychologist and president of the Ordre des psychologues du Québec, do you think that the trend observed in the Netherlands would probably be the same here in Canada?

Dr. Christine Grou: I always have trouble formulating a hypothetical answer when there are no data.

I can speak from my clinical experience, though. I did work in psychiatry for 25 years and chaired the ethics committee.

In general, patients with mental disorders want to live, get better and recover. This is the case for the majority of patients. The majority of health problems are treatable, even those that are complex or unresponsive.

In my life, I have seen two cases, one of which involved a patient who was very determined to end his life and who wanted to die humanely because he was not capable of living.

You know, in psychiatry we sometimes meet people whose lives give the impression that all the misery has been dumped on them. When I talk about misery, I'm talking about human misery, trauma, hardship, fighting, illness, lack of resources, poverty and social isolation.

There are cases where all of these elements are concentrated in one person. This often occurs in cases of severe mental disorder. I haven't often seen people who spontaneously say they have a desire for death or want to die.

Let's take the eligibility criteria. I truly believe that nothing is simple for caregivers who are trained to treat health problems and rehabilitate patients.

You know, in ethics, we find that it's much harder to respect a patient's decision when it offends our values, when it goes against what we want for them. So when we offer a treatment, and we think it's going to work, we establish a therapeutic alliance, and generally the patient wants it, because they want to get better—

The Joint Chair (Hon. Marc Garneau): I'm sorry to have to interrupt you, Dr. Grou.

[*English*]

We will go to Senator Martin now for three minutes.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Chair.

Thank you to all of the witnesses for appearing before our committee.

My first question is for Mr. Henick.

Some witnesses have told this committee that excluding people who suffer solely from mental disorders is discrimination. As a person who advocates for this community, what are your thoughts on that?

Mr. Mark Henick: I think that people with mental health problems and illnesses are already being discriminated against routinely. Our rights are routinely violated, and that's actually the problem. That's what's getting us to the point where we feel we have no other option than to request MAID. There has already been a long line of violations to the rights of people with mental illnesses that, in my view, supersedes any further action in this regard.

● (2030)

The Joint Chair (Hon. Yonah Martin): Thank you. On a personal level, I just want to say that your testimony was very compelling, and it does give all of us hope for the way that we can be looking at people with mental disorders, so thank you for your strength and courage.

Dr. Kelleher, witnesses have provided conflicting testimony as to whether MAID can be entirely distinguished from suicide. It's really important for us to have an answer to that question. Would you share your thoughts on that?

Dr. Eric Kelleher: Often there is a suggestion that there are differences between the patient who has a depressive illness and who is suicidal and one who has MAID. In practice, there is very little difference to distinguish between those two things. There is very little suicidal behaviour—whether it's lethal or non-lethal, of course—without planning. In fact, impulsive attempts are associated with people who have, possibly, a lower psychopathology. Individuals who make planned attempts at suicide are more likely to be depressed and hopeless compared to those who make unplanned attempts.

The clinical profile, as my colleague Dr. Nicolini highlighted earlier, appears to be similar in MAID and suicidal behaviour, as evidenced by the high prevalence of women in both situations. Therefore, it's unclear whether or not we can draw a firm distinction between MAID and suicidality, which poses a major problem for the practice of MAID for mental disorders.

The Joint Chair (Hon. Yonah Martin): That concludes this second panel, and we are exactly on time.

Again, thank you to all of our witnesses for helping us work through this very difficult topic and for lending us your expertise.

Colleagues, with that, I call this meeting to an end. We are adjourned.