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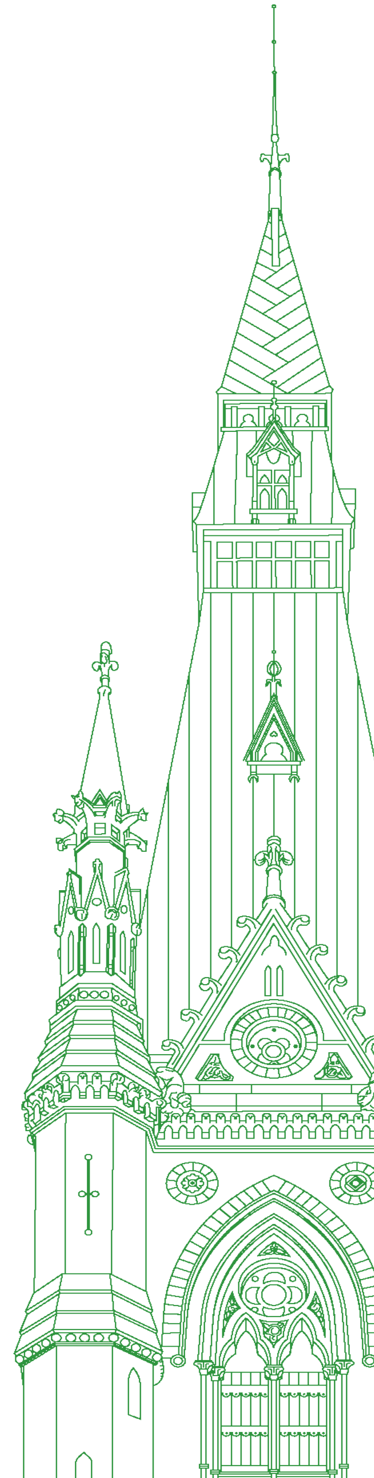

Co-Chairs: Mr. René ArseneaultThe Honourable Yonah Martin

Special Joint Committee on Medical Assistance in Dying

Tuesday, November 7, 2023

● (1830)

[*Translation*]

The Joint Co-Chair (Mr. René Arseneault (Madawaska—Restigouche, Lib.)): Good evening.

Welcome to this meeting of the Special Joint Committee on Medical Assistance in Dying. I would like to welcome members of the committee and witnesses, as well as those watching this meeting on the web.

[*English*]

My name is René Arseneault, and I am the House of Commons joint chair of this committee. I am joined by the Honourable Yonah Martin, the Senate's joint chair of this committee.

[*Translation*]

Today, we begin our examination of the degree of preparedness attained for a safe and adequate application of medical assistance in dying, where mental disorder is the sole underlying medical condition, in accordance with recommendation 13 of the committee's second report.

[*English*]

I would like to remind members and witnesses to keep their microphones muted, unless recognized by name by the joint chairs. I remind you that all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly, and as near as you can to the microphone for the interpreters. Interpretation in this video conference will work like in an in-person committee meeting. You have the choice at the bottom of your screen of floor, English or French.

[*Translation*]

With that, I would like to extend a virtual welcome to our witnesses for our first panel.

From the Canadian Psychiatric Association, we have Dr. Alison Freeland, chair of the board of directors and co-chair of the MAID working group.

[*English*]

We also have the Canadian Bar Association, represented by Ms. Shelley Birenbaum, chair of the end of life working group.

Thank you for joining us, Ms. Freeland and Ms. Birenbaum.

We'll begin with opening remarks by Dr. Freeland, followed by Ms. Birenbaum.

I will be very strict with the time for everyone here tonight because we'd like to have at least two rounds. If you ask a question with 10 seconds remaining in your time, there will be no answer. I'd ask everyone to try to be as tight as you can on your time. Then we can have two rounds of questions for everyone.

Dr. Freeland, the floor is yours for five minutes.

Dr. Alison Freeland (Chair of the Board of Directors and Co-Chair of MAID Working Group, Canadian Psychiatric Association): Thank you.

My name is Alison Freeland. I am a psychiatrist, and I am here in my capacity as chair of the board of directors of the Canadian Psychiatric Association and co-chair of the CPA's medical assistance in dying working group to provide you with the CPA's perspective. Thank you for the opportunity to be here today as you consider the degree of preparedness attained for a safe and adequate application of MAID for MD-SUMC.

As the national voice of Canada's psychiatrists and psychiatrists in training, the CPA's mission is to promote the highest quality of care and treatment for persons with mental illness and to advocate for the professional needs of our members by promoting excellence in education, research and clinical practice.

The CPA does not take a position on the legality or morality of MAID, nor has the CPA taken a position on whether MAID should be available where mental illness is the sole underlying medical condition. However, the CPA does believe that any legislation must protect the rights of all vulnerable Canadians without unduly stigmatizing and discriminating against those with mental disorders solely on the basis of their disability.

The CPA's primary contributions towards preparedness have focused on providing feedback and input on national standards and the training curriculum, facilitating member awareness and education on MAID and contributing to the literature regarding MAID. Through our working group, the CPA provided feedback on the MAID practice standard prior to its release last March. The CPA was also part of the national MAID curriculum steering committee, which supported and enabled the development of a training curriculum for assessors and providers that was released in September. In addition, several CPA members have been part of the CAMAP working groups that developed individual curriculum modules.

The CPA regularly informed members about the development of the practice standards and their contents as well as the curriculum through our weekly members newsletter. We continue to keep our members abreast of and facilitate relevant MAID training opportunities.

At our 2022 annual conference, we held a panel discussion for 140 participants that explored ethical considerations to guide MAID decisions, assessment of capacity and voluntariness, and suicide versus MAID. More recently, our annual conference last month included a plenary that discussed the need for a national MAID curriculum and outlined its development. More than 300 conference delegates participated in this session.

In conjunction with the conference, we also hosted a facilitated session of the MAID and mental disorders curriculum module for CPA members who are licensed clinicians. It's my understanding, from informal discussions with systems partners, that approximately 100 psychiatrists are now registered for the MAID curriculum. We continue to promote future educational opportunities for this training through our newsletter.

Our peer-reviewed journal, The Canadian Journal of Psychiatry, has published a number of articles that seek to clarify aspects of MAID, including original research by van Veen and colleagues that establishes 13 consensus criteria for determining irremediability in the context of MAID in the Netherlands. While psychiatrists diagnose, treat and assess capacity in people with mental disorders on a daily basis, we will soon publish a paper on the capacity to consent in the context of MAID in The Canadian Journal of Psychiatry, and this will offer further guidance to our psychiatrists. Our MAID working group continues to be active and will meet shortly to consider further topics where members would benefit from additional guidance.

The CPA also has some knowledge of health systems readiness gained through members of our working group as well as from our Council of Psychiatric Associations, which facilitates an exchange of information on issues of national importance by assembling the presidents of the various provincial psychiatric associations.

As a national member organization, our role is to listen to and dialogue with our members. While some psychiatrists do not support MAID, others are interested in learning more and will choose to be involved with MAID as consultants or assessors and possibly providers. Psychiatrists' expertise is important when it comes to MAID, but we do not practise in isolation. We work in interprofessional teams that centre the voice and lived experience of the patient and their family to balance treatment, care and hope for recovery with a capable person’s right to make health care decisions.

Thank you, and I would be happy to answer questions.

● (1835)

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Freeland.

Ms. Birenbaum, the floor is yours for five minutes.

Ms. Shelley Birenbaum (Chair, End of Life Working Group, The Canadian Bar Association): Good evening, Chairs and honourable members of the committee. My name is Shelley Birenbaum, and I am chair of the end of life working group of the Canadian Bar Association. Thank you for the opportunity to address your committee.

The CBA is a national association of 37,000 lawyers, Quebec notaries, law teachers and students, with a mandate to promote improvements in the law and the administration of justice. The CBA end of life working group comprises a cross-section of members drawn from diverse areas of expertise, including constitutional and human rights law, criminal justice, health law and child and youth law.

Medical assistance in dying, or MAID, is complex and raises vital issues and diverse views and the need to balance the competing values of autonomy and protection of those who may need it. At the same time, we must realize that the suffering of individuals with mental illness is no less real than that of individuals affected by physical illness, and persons with mental illness should have the same agency to determine their health care treatment as persons with physical illness, as long as they meet the requirements to do so.

We make three main points for this committee to consider. First, a total exclusion from MAID for all persons suffering from mental illness as a sole condition is likely to be constitutionally challenged as violating the equality, security and liberty guarantees in the Canadian charter. Second, there are already legislated procedural safeguards in the Criminal Code to protect those with mental illness as a sole condition and who may be vulnerable. Third, additional guidance, as pointed out by Ms. Freeland, is available for health professionals and has been developed to help clinicians.

To give more detail on constitutionality, a general exclusion of all persons suffering from mental illness is likely to be constitutionally challenged as discriminating against those with mental illness and denying them equality under the law, contrary to section 15 of the charter. A blanket prohibition increases suffering and will likely result in breaches of the rights to security of the person and liberty, that is, the ability to make decisions regarding bodily integrity guaranteed to us under section 7 of the charter.

There are existing legislative safeguards. The Criminal Code already establishes a robust series of procedural safeguards that must be met before a person is considered eligible for MAID, including decisional capacity, two independent assessments and informed consent. The safeguards for track two, where death is not reasonably foreseeable—and most mental illnesses would likely fit within that category—are even more rigorous, requiring a prescribed and robust informed consent, consultation with an expert in the field, a reflection period and a determination that there has been a serious consideration of options.

Health care practitioners are already legally required to assess capacity prior to treatment, and psychiatrists regularly make capacity determinations for persons with mental illness, provide prognoses about mental illnesses and assess risk of suicidality, which are different than MAID. Any additional safeguards must not unduly prolong the suffering of those who are otherwise eligible for MAID and should align with current best practices in mental health care.

We understand that there have been many tools developed, and many recommendations of the expert panel on MAID and mental illness are being implemented to ensure a state of readiness. We are aware of the “Model Practice Standard” and “Advice to the Profession” documents that have been developed, as well as the comprehensive Canadian MAID curriculum, with a specific module on mental illness and MAID. In addition, provinces and territories and regulatory bodies may continue to develop guidance and tools in their role in regulating health and health practitioners.

MAID where mental illness is the sole condition has been under consideration for almost nine years and has been delayed twice. We are of the view that eligibility should no longer be delayed and that the planned March 2024 implementation date should be respected.

On behalf of the CBA, thank you again for the opportunity to speak today. I look forward to answering any questions you may have.

● (1840)

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Birenbaum.

I'd like to thank both witnesses for respecting their speaking time.

I'll now give the floor to the committee's joint co-chair.

[*English*]

The Joint Chair (Hon. Yonah Martin (Senator, British Columbia, C): Thank you to our witnesses for being here this evening.

Colleagues, I'll just remind you that we have to be strict with our time due to the time constraint.

We'll begin with our first round of questions of five minutes each for each person representing the parties.

We'll begin with Mr. Fast for five minutes.

Hon. Ed Fast (Abbotsford, CPC): Thank you, Madam Chair.

My first questions will be for Dr. Freeland.

Dr. Freeland are you appearing at our committee today on behalf of the psychiatric profession at large, on behalf of a working group or on your behalf?

Dr. Alison Freeland: Just to restate, I am here on behalf of the Canadian Psychiatric Association, which is the national member association for Canadian psychiatrists and psychiatrists in training. My role with the CPA is chair of the board of directors. I also co-chair our working group focused on medical assistance in dying.

Hon. Ed Fast: Thank you.

Do you speak for all psychiatrists?

Dr. Alison Freeland: I'm speaking on behalf of the CPA, which represents our psychiatrist members. As a national member organization, approximately 50% of psychiatrists are members of our association. That has been a very steady rate over the last number of years. We've also been very pleased by an increase in our members in training of approximately 19% over the last year. We were also—

Hon. Ed Fast: Thank you. Then you represent about half of Canadian psychiatrists.

I wanted to know something. You chaired a committee that studied MAID for the mentally disordered. I understand that your committee stated, in March 2020, that mentally disordered patients should have the same access to MAID as is available to all patients. You've restated that today in your testimony.

I understand that the CPA has never formally consulted with its members in the lead-up to the position statement that was issued by the committee. Is that correct?

● (1845)

Dr. Alison Freeland: I'm happy to explain our process for both position statements and how we've undertaken member consultations.

The CPA routinely publishes position papers and statements on issues related to psychiatric practice, and we have a way of proceeding with that. Through our MAID working group, we did have a number of member consultations, which have included, since 2016, member surveys. There's been an original time-limited task force and we've had symposia—

Hon. Ed Fast: Doctor, I'm not asking you to explain exactly how the consultation process worked. I just want to know if there were formal consultations with your membership. Has that membership actually given you a clear consensus that they want you to move forward with this?

Dr. Alison Freeland: Are you asking particularly in reference to the publishing of the position statement, which was published and then amended when Bill C-7 came through, along with our discussion paper, our two surveys and the town hall?

Hon. Ed Fast: Yes, let's talk firstly about the position statement you issued.

Dr. Alison Freeland: Our process for the position statement would be for our professional standards and practice committee to develop something that's based on CPA policy. We did not take a position on the morality or ethics of MAID as it relates to mental illness or whether or not mental illness should be part of it.

Hon. Ed Fast: I understand that.

Dr. Alison Freeland: What we did was underscore the importance of not stigmatizing a group of people by virtue of their illness.

Hon. Ed Fast: Did your consultations result in you divining or discerning a consensus among your members that MAID was ready to be implemented for the mentally ill?

Dr. Alison Freeland: I think it's very well known that across all Canadian psychiatrists, including within our membership at the CPA, there are people with different perspectives with respect to MAID for mental illness—

Hon. Ed Fast: Okay, so there is no consensus.

Dr. Alison Freeland: As a member organization, we welcome healthy debate, which continues. Part of the work we did was to develop—

Hon. Ed Fast: That's all I need to know. There's really no consensus within your profession at this point in time. Is that correct?

Dr. Alison Freeland: I think if you're asking about 100% consensus for some sort of intervention on the issue of people with mental illness, it would not be unusual to consider that there's generally not consensus in many aspects of medicine.

I'm sorry. I'm not sure if I'm answering your question.

The Joint Chair (Hon. Yonah Martin): You have about 15 seconds.

Hon. Ed Fast: Is that it? My goodness. Thank you.

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

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

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

I want to thank both witnesses for being here today.

I want to pick up on something you said, Dr. Freeland. I'm assuming you've read the reports from this committee in its previous incarnations.

Dr. Alison Freeland: Yes, I've had the opportunity to read them.

Mr. James Maloney: In our report in June 2022, we recommended the following:

> We must have standards of practice, clear guidelines, adequate training for practitioners, comprehensive patient assessments and meaningful oversight.... This task will require the efforts and collaboration of regulators, professional associations, institutional committees and all levels of government and these actors need to be engaged....

Do you agree with that statement?

Dr. Alison Freeland: I think those are important parts of being ready for this. Yes.

Mr. James Maloney: Thank you.

You mentioned that you were—I assume, based on what you told Mr. Fast—involved in the practice standards development process on behalf of the CPA. Is that correct?

Dr. Alison Freeland: We were asked as the CPA organization to provide some representation and contribute to the development of the standards, yes, and give feedback.

Mr. James Maloney: Okay, and if I heard you correctly, you said that 100 psychiatrists have registered for the curriculum so far. Is that what you—

Dr. Alison Freeland: That is what I understand regarding the people who are registered for that. I can call myself one of them.

Mr. James Maloney: Okay. Thank you for that.

You said that about 50% of the psychiatrists in Canada are part of your organization. How many psychiatrists are there in Canada?

Dr. Alison Freeland: There are just shy of 5,000. We are at just under 2,500 psychiatrists.

Mr. James Maloney: Okay. One hundred out of 5,000 psychiatrists in Canada signed up to be part of this new curriculum for providing MAID to people with mental illness. Is that correct?

● (1850)

Dr. Alison Freeland: In terms of who is currently signed up, that is the information I have been provided. I would say that the CPA is not monitoring the exact number of psychiatrists participating—

Mr. James Maloney: Okay, but you would agree with me that this is a pretty low number. My math is not very good, and I'm not going to guess the percentage, but it's not very high.

Don't you think it would be appropriate that, before this process is rolled out, a much larger number of your members have not just registered for but completed the curriculum?

Dr. Alison Freeland: I'm sorry, but you cut out at the last minute there.

Mr. James Maloney: Let me put it another way. Would you agree with me that it is important that anybody who is being consulted on MAID for somebody with a mental illness has participated in and taken courses as part of this curriculum?

Dr. Alison Freeland: I think one of the things to consider—and I think Ms. Birenbaum did a really nice job of elucidating this—is that psychiatrists are trained on a number of the important issues as experts providing consultation to a process of assessment for MAID. All psychiatrists undertake a minimum of five years of training, and what we focus on is diagnostic assessment, treatment planning, evidence-based approaches—

Mr. James Maloney: I don't want to interrupt and I don't want to be rude, but I'm limited in time.

I agree with you that psychiatrists undergo some very serious training—extensive training—but you have been part of this process development and have helped to prepare this curriculum, yet only a very small number of psychiatrists have taken part in it. Do you not think it would be preferable if a much larger number of your membership—and in fact psychiatrists across Canada—take the courses before they participate in the process?

Dr. Alison Freeland: Those courses have only just been launched. The curriculum has only been made available since the fall.

Mr. James Maloney: That's precisely my point.

In our mandate at this committee, we've been tasked with determining the state of readiness. If only 100 out of 5,000 psychiatrists have taken courses in this curriculum.... I'm sorry. In fact, they haven't taken them. They've registered for courses in the curriculum. Would you agree with me that perhaps that casts some doubt on readiness?

Dr. Alison Freeland: I'm not sure about that.

I would still stand by the role psychiatrists can play as part of MAID and assessment. The point of being an expert and providing an expert opinion to those who may be trained to be assessors and providers.... I believe that's what's stipulated as part of the Criminal Code, and I believe that would be a role that many psychiatrists could play. They are already trained to provide expert consultation and opinion.

Mr. James Maloney: I'm running out of time.

The Joint Chair (Hon. Yonah Martin): You have 30 seconds.

Mr. James Maloney: Ms. Birenbaum, you said that the subcommittee has 37 members who are part of the Canadian Bar Association.

Ms. Shelley Birenbaum: No. I said there are 37,000 lawyers who are part of the Canadian Bar Association.

Mr. James Maloney: All right.

Ms. Shelley Birenbaum: I represent the end of life working group, which is a subcommittee of the Canadian Bar Association.

Mr. James Maloney: I'm going to ask both of you this question.

Is it fair to say that there is not consensus between the legal community and the medical community—in your case, the psychiatric community—about the state of readiness? I'm aware of a number of organizations that have made it clear that they believe they are not ready.

The Joint Chair (Hon. Yonah Martin): I'm sorry, but we are out of time.

Perhaps there could be a quick answer, a yes or no. Is there consensus? Okay.

I'm sorry about that. We'll move on to the next questioner.

Monsieur Thériault, you have five minutes.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Thank you very much.

Dr. Freeland, Ms. Birenbaum said earlier that she thought we had to move forward in March 2024. Do you share that view, or does your association?

[*English*]

Dr. Alison Freeland: Just to clarify, are you asking me if our association is of the same opinion as the Canadian Bar Association, that we should go forward in March with MAID for mental illness?

[*Translation*]

Mr. Luc Thériault: Yes.

[*English*]

Dr. Alison Freeland: It's a complex issue. Part of what we've been trying to state is that we are working towards readiness. The important thing from a Canadian Psychiatric Association point of view is that we are one part of a team of health care providers who are involved in medical assistance in dying for mental illness. Many of the things we are worrying about have already been part of the assessments for MAID. For people with any track two condition, many of the things we're thinking about are related to issues there.

● (1855)

[*Translation*]

Mr. Luc Thériault: Okay.

I thought my question was simple. You're not in a position to give me a yes or no answer. I understand that.

In a number of writings, it is said that, roughly speaking, 50% of psychiatrists are reluctant to make medical assistance in dying available to people with mental disorders. In the brief you submitted to the joint committee in May 2022, you wrote:

> … it is essential that at least one independent psychiatrist who has expertise in the mental disorder in question completes a comprehensive clinical assessment to validate whether the patient has received an accurate diagnosis and if they have had access to evidence-based mental health assessment, treatment and supports for an adequate period of time based on generally accepted standards of care.

This view, that an independent psychiatrist with expertise in the mental disorder in question is needed, is also found in recommendation 10 of the final report of the expert panel on medical assistance in dying and mental illness.

Do you think we have the necessary resources to implement that recommendation?

[*English*]

Dr. Alison Freeland: The first thing I will restate is that I believe psychiatrists do have expertise in some of the areas that are pertinent to assessment in MAID, such as the diagnosis and understanding of refractory illness, capacity issues and the assessment of suicide. What we've learned is more about MAID and its delivery, and we understand that no one profession can do this alone. We do feel that in most cases of MAID for mental illness—

[*Translation*]

Mr. Luc Thériault: You're not answering my question. Perhaps it's a problem with the interpretation.

Mr. Chair, I hope you'll take that into account in the allocation of my speaking time.

I'm asking you whether we have enough resources and psychiatrists to respond to recommendation 10 of the expert panel on medical assistance in dying and to the similar recommendation you put in your brief.

Was my question clear enough?

[*English*]

Dr. Alison Freeland: What you're asking me is whether we have enough psychiatry resources to do this. We have to step back and say that when we look at mental health and addictions, we don't have enough resources for all kinds of things that we do in the delivery of mental health care and the provision of expert opinion on the different issues. That being said, where an expert opinion is needed in MAID, we need to gather the necessary information to determine eligibility. People may need to wait for that resource to occur—to get the right information that's needed to make a decision.

Do we have enough psychiatrists specifically for MAID? We probably do not. Do we have enough psychiatrists for the delivery of mental health care in general? We do not necessarily, and the same applies for many other medical specialities, where people may wait for an expert opinion for other conditions that are being considered for track two.

[*Translation*]

Mr. Luc Thériault: If I understand correctly, you want to make the obligation to have an independent psychiatrist who is an expert in the mental disorder an additional safeguard, and you're telling us this evening that you don't know whether we have the resources to offer medical assistance in dying to people with mental disorders.

Am I coming to the right conclusion?

[*English*]

Dr. Alison Freeland: No, I think I'm saying that what we understand is there are not enough resources in many aspects of health care. What we know is that in terms of the number of psychiatrists available to Canadians, there are probably not enough and we continue to have a wait-list for people to access expertise.

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

We have Mr. Angus, who's online tonight.

You have five minutes.

Mr. Charlie Angus (Timmins—James Bay, NDP): Thank you, Chair.

I have a simple question, Dr. Freeland. In four months, Canada's going to cross a line that we probably won't come back from. Are we ready?

Dr. Alison Freeland: I think that's part of what we're trying to ascertain today.

In thinking about readiness, there are different aspects to readiness. Are we ready from a national perspective? Do we have the appropriate national standards? I think we do have those. Do we have a nationally available training curriculum for people? I think we've been able to do that. When we think about—

Mr. Charlie Angus: Do you think so? I'm sorry. The committee's final report in February 2023 noted, "there has not been sufficient time to develop the standards of practice" that "are key to ensuring a thoughtful, consistent approach to MAID".

I have found, in all my years of Parliament, that things don't move very fast. To suddenly go from February to now and say we're ready...I have a really hard time buying that. We were given an arbitrary date on this by the unelected Senate, which threw in March 2023. Then the Liberals moved it to 2024.

Can you tell me with assurance that I can go back to the people I represent and tell them not to worry, that if their loved one who's severely depressed decides he's going to end his life, it will be done right with all the provisions and protections? Can you tell me that I can tell people those protections are in place now, because in four months this will become law?

● (1900)

Dr. Alison Freeland: I don't think that from a CPA perspective I can say all the readiness is there, because for health systems readiness, the CPA wouldn't have all the information necessary to make a comment on that. I can comment on clinical readiness and standards.

Mr. Charlie Angus: That's crucial. We're supposed to know it's going to be "rationally considered during a period of stability, not during a period of crisis", which may require serial assessments.

That sounds great, but that is not like anything I've ever seen in the real world. We deal in our office with people who have severe depression. We deal with families that deal with loved ones who are in a deep, dark, black hole, and we deal with the fact that many families don't have doctors or have never seen a psychiatrist.

In four months, thanks to how this has been set up, this becomes law and someone who's in a deep, dark depression can end their life. How do I tell their family that everything was done to make sure they had all their agency? How do I tell them not to worry, that if this person who's in a deep, dark depression decides to end their life, the process is there to protect them?

Dr. Alison Freeland: I think one thing we have to think a bit about is that just because somebody applies for an assessment for medical assistance in dying does not mean they become eligible for it.

The standards, with advice to the professions as part of the standards, clearly articulate some of the things that need to be carefully considered as part of an assessment. I believe there's been a lot of thought and attention to build those standards, disseminate them and provide advice. From that perspective, we do have those things.

Mr. Charlie Angus: I don't doubt that and I'm not questioning the deep integrity of people in the psychiatric profession, but we have a situation.... I deal in the real world. I don't deal in what should be; I deal with what I see. I represent the Far North, where we have a horrific suicide crisis in indigenous communities. We have an ongoing mental health crisis, in fact, to the point that states of emergency have been declared.

When I ask you if we are ready, I need to know that I can go back to Treaty 9 and say, yes, for a loved one who's severely depressed and wandering the streets, if they decide they're going to end their life, all the protections are in place to make sure this was done right. If those protections aren't right, it's our duty to tell the public we're not ready.

Can you tell me the protections are there?

Dr. Alison Freeland: I don't think I can do that.

I believe that a lot of time and effort has been put into doing this. I am reflective of some of the comments my colleague made at the beginning of this. We've had quite a long time to think about it.

We have allowed other complex medical disorders to be involved in track two MAID, with a lot of similar issues related to mental disorder, so we have to think about that.

Mr. Charlie Angus: Certainly, but we have a deadline of four months that the Liberal government has put on us, so in four months this becomes law. We break for the Christmas season very soon, and then we're out for January.

Again, I need to be able to tell people not to worry; when this becomes law, all these things will have been thought out. I haven't heard that answer yet.

The Joint Chair (Hon. Yonah Martin): Unfortunately, we are out of time.

Mr. Charlie Angus: Thank you.

The Joint Chair (Hon. Yonah Martin): We'll move on to questions from senators.

[*Translation*]

The Joint Chair (Mr. René Arseneault): Senator Mégie, you're going to start us off.

You have three minutes.

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

I have a question for each of the witnesses. I would like a quick answer.

My first question is for Dr. Freeland.

Have training activities already begun for psychiatrists who will have to provide medical assistance in dying? I'd like a yes or no answer.

● (1905)

[*English*]

Dr. Alison Freeland: Yes.

[*Translation*]

Hon. Marie-Françoise Mégie: Okay.

I know that there's already a lack of psychiatric resources to treat patients. So it will have to be shared, psychiatrists will have to follow patients, and others will deal with medical assistance in dying.

Do you have any idea what percentage of psychiatrists want to take this training?

[*English*]

Dr. Alison Freeland: No, I am not sure about that.

[*Translation*]

Hon. Marie-Françoise Mégie: Okay, thank you.

Ms. Birenbaum, I'd like to know what criteria the Canadian Bar Association has already established to safely provide medical assistance in dying to people with mental illness.

[*English*]

Ms. Shelley Birenbaum: We ourselves as lawyers did not develop criteria. What we have done is look at what's existing now within legislation. If you look at all of those safeguards, especially for "not reasonably foreseeable", it's a reasonably robust set of safeguards that would ensure people are ready to access MAID. They have to be deemed eligible. It seemed to us that that was a strong legal framework.

Do you want me to articulate the criteria that are in the Criminal Code?

[*Translation*]

The Joint Chair (Mr. René Arseneault): You have 45 seconds left.

Hon. Marie-Françoise Mégie: We could check the Criminal Code.

Thank you very much.

The Joint Chair (Mr. René Arseneault): You still have 45 seconds left, Senator Mégie.

Hon. Marie-Françoise Mégie: No, it's okay. I'll give it to my colleague.

[*English*]

The Joint Chair (Mr. René Arseneault): The next questions will be asked by Senator Kutcher.

The floor is yours for three minutes.

Hon. Stanley Kutcher (Senator, Nova Scotia, ISG): Thank you very much to the witnesses.

I'll use my questions, first, to clarify.

The Canadian Psychiatric Association does not represent any psychiatrists in Quebec. Is that fair?

Dr. Alison Freeland: That would be fair.

Hon. Stanley Kutcher: If you take the CPA and the AMPQ together, that's about 75% of psychiatrists in Canada.

Dr. Alison Freeland: Can I reframe that? We do have Quebec members who are part of the CPA and the AMPQ. My apologies.

Hon. Stanley Kutcher: Yes. Together it's about 75%.

There was a question about the large number of psychiatrists needed, but we know from the data of the Benelux countries that a very small number of people with a sole mental illness would qualify for MAID. We really have no idea whether we need 5,000 psychiatrists—likely not—or at the beginning we can get by with 100 or 50. This idea that we need a large number of psychiatrists.... I don't know if that makes sense. Does it make sense to you?

Dr. Alison Freeland: I would agree with that. There are a lot of examples, both in mental health and in medicine at large, where not everyone is part of a new thing that comes out. Not everyone is trained to do everything in all aspects of health care.

Hon. Stanley Kutcher: Then the idea that we need thousands of psychiatrists is erroneous.

In terms of readiness—and I think you used a nice phrase for that—have the standards of medical practice been developed?

Dr. Alison Freeland: Have the standards for medical practice been developed? We have the national standards, which have been developed with advice to the profession, yes.

Hon. Stanley Kutcher: What about the curriculum? Has that been developed?

Dr. Alison Freeland: That is correct, yes.

Hon. Stanley Kutcher: It is available for psychiatrists and for any other physician in the country who wishes to take it.

Dr. Alison Freeland: That's correct.

Hon. Stanley Kutcher: Are there ongoing programs right now for more psychiatrists? Five months ago, how many psychiatrists had taken the program?

Dr. Alison Freeland: There wouldn't have been any, because we didn't have—

Hon. Stanley Kutcher: We've had a 100% increase in a very short time.

Dr. Alison Freeland: That's correct. I will say that for the one I tried to register for, I am now on a wait-list because I can't [*Inaudible—Editor*].

Hon. Stanley Kutcher: I can do my math.

The point here is that we're on a trajectory for creating competencies. I know of no speciality in medicine where all the competencies are done on day one. We have a huge trajectory for creating competency. We have to be careful not to give an improper idea about medical training.

I'll go to Ms. Birenbaum.

We're seeing some confusion in the committee about assessing readiness between provincial jurisdiction and federal jurisdiction. Our job as the federal government is to assess readiness solely in terms of steps within the federal government's jurisdiction.

I'm wondering whether you think the exclusion of people is a limit on charter rights. What prospects do you think a claim of lack of readiness would have as a justification for a limit on rights? How would the Supreme Court look at a justification of provincial non-readiness?

● (1910)

The Joint Chair (Mr. René Arseneault): You have 10 seconds.

Ms. Shelley Birenbaum: I can only indicate that we've had about nine years to think about this. I think there have been three years of delay, during which there was an absolute exclusion. I think a court would consider the fact that there have been so many years available, if they look at whether or not it's a justifiable exclusion.

I also think that—

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Birenbaum.

[*Translation*]

Senator Dalphond, you now have the floor for three minutes.

Hon. Pierre Dalphond (Senator, Quebec (De Lorimier), PSG): Thank you, Mr. Chair.

[*English*]

Hon. Pierre Dalphond: Maybe I will follow up on Senator Kutcher's question to you, Ms. Birenbaum. I will give you a few more minutes to complete your answer. I had similar questions.

How can the law navigate potential tensions between the Charter of Rights—guaranteed rights, as you referred to mentally ill patients also having rights—and the fact that we may also need to have the proper standards and training in place to protect vulnerable persons? How do we balance the absolute right, in one sense, to have access with the right to protect the vulnerable? If the conclusion of the committee is that there's not enough readiness, would you say that goes to the standards in section 1 of the charter?

Ms. Shelley Birenbaum: Certainly a lack of readiness could go to section 1 of the charter. However, looking at the legal framework for protecting a vulnerable person, I think there are protections built into that. A person must be capable, first of all. That is what people do all the time in health care. Is the person capable of making this decision? You're going to root out the people who are incapable; then you're going to see whether there were enough treatments looked at, etc. Have the means been established?

Going through the MAID assessment process is itself a guarantee of protection of the vulnerable. That would go to the weight of section 1. There are significant protections there.

Hon. Pierre Dalphond: Should we make a distinction between legal protections and practical protections in the field?

Ms. Shelley Birenbaum: I'm assuming, given that health care practitioners have criminal liability, that they have to sign off that all the criteria have been met. If they haven't been met, they are criminally liable. In my experience with MAID practitioners—and I've known quite a few—they take this very seriously. In terms of practicalities, I'm hopeful they will abide by the legal parameters.

The Joint Chair (Mr. René Arseneault): Senator Osler, the floor is yours for three minutes.

Hon. Flordeliz Osler (Senator, Manitoba, CSG): Thank you, Mr. Chair.

Thank you to the witnesses for being here today.

My questions are for Dr. Freeland.

We've heard there are psychiatrists who have started training. My question is, how prepared are psychiatrists who are either involved in assessing MAID requests or acting as consultants to MAID assessors? Can you give us an idea of how prepared they are now, and how prepared they will be in five months?

Dr. Alison Freeland: Again, where there are requirements for consultation with an expert, I believe psychiatrists are prepared to do that. It is part of their core business to provide expert consultation around key areas of diagnosis, review of treatment plans, capacity assessments, suicidal assessments, comorbidities, etc.

In terms of any practitioner who is now looking at how to become involved in being an assessor of eligibility, we know some psychiatrists are already involved in doing that. We had one of them presenting at a conference last month. Others are actively involved in that. It is a small number who are actively part of the provision.

There will be growth in the number of psychiatrists involved in those two specific areas. I don't anticipate there will be a lot of psychiatrists being the assessors of eligibility and providers of MAID. I think the area where we will see the involvement of psychiatrists is as experts in the assessment of illness and some of the important aspects of that.

● (1915)

Hon. Flordeliz Osler: Dr. Freeland, has it ever occurred that a new practice in psychiatry has started and some individual psychiatrists were not ready to be involved, but that practice went ahead anyway? How did the CPA respond to such occurrences—for example, ketamine or psilocybin treatment?

Dr. Alison Freeland: Those are great examples, and a couple that I would have raised. The rTMS would be another one. These are active, new practices and innovative aspects of psychiatric treatment and care. There are a limited number of people who have expertise in them. The CPA becomes involved because of our focus on the mission of ensuring that we provide educational opportunities or access to them to help people learn more and become more engaged and familiar with some of these things. That is how we offer opportunities to our members in those areas.

Senator F. Gigi Osler: Thank you.

The Joint Chair (Mr. René Arseneault): You still have 20 seconds.

Hon. Flordeliz Osler: I'm good.

The Joint Chair (Mr. René Arseneault): Mrs. Martin, the floor is yours for three minutes. I'll be tight on time.

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

I know there have been questions about readiness, and there is concern about the overall readiness. You've responded to some of the questions about the lack of....

I'm curious about a survey from October 1, 2023, of psychiatrists in Manitoba. Only 33% of them responded that they were in favour of the legislation and legalizing MAID for mental illness. In that same survey, 65% of respondents said they do not have enough awareness or understanding of MAID. This speaks to the lack of readiness or concerns of readiness.

Would you first speak to the 33% of psychiatrists who are in favour of the legislation?

Dr. Alison Freeland: The 33% who are in favour....

The Joint Chair (Hon. Yonah Martin): Only 33% are in favour of legalizing MAID for mental illness.

Dr. Alison Freeland: I think a number of different surveys have been done, and I don't think any survey had 100% of psychiatrists in favour of doing that. There could be all kinds of different reasons for that. It could be how the questionnaire was set up, or it could be people not having enough training and understanding of the issue. Some people are in disagreement with this as a concept.

I think one of the challenges in all of this is that it's something Canada has decided should be made available to its citizens. In some regards, although it's important to consider what psychiatrists' contributions are, at the end of the day, whether psychiatrists want this or not, it's a legal thing that's available to Canadians. We have to consider that perspective in all of this. I think it's important—

The Joint Chair (Hon. Yonah Martin): Thank you. I have limited time.

In that same survey, only 65% of respondents said they have enough awareness or understanding of MAID for mental illness. Because psychiatrists are on the front lines and must be ready, what would you say to that?

Dr. Alison Freeland: I would say that we are continuing to try to provide opportunities for people to increase their understanding and awareness. We are making available a connectivity to the curriculum that has only just come out. I think there are an increasing number of places where psychiatrists who choose to become more familiar and more engaged with all of this can receive the training to support medical assistance in dying assessments.

The Joint Chair (Hon. Yonah Martin): We have heard concerns about the rural and urban issues and that there's an urgent need in rural communities. The fact is that there is a lack of psychiatrists in some of these parts. What would you respond to these concerns?

Dr. Alison Freeland: I think it's a really important question. It's something separate from this issue, but the CPA would advocate on the importance of access and on how we build it. I think the use of telepsychiatry is an important step in helping to improve access for people in rural and northern areas.

Looking at the regionalization of licensure, there's been some activity on how we do that to support Canadians in accessing psychiatry in general, not even just for the issue related to MAID.

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Freeland.

● (1920)

The Joint Chair (Hon. Yonah Martin): We're able to go into a second round.

Mr. Fast, you have three minutes.

Hon. Ed Fast: Thank you very much.

My questions are for Ms. Birenbaum.

Ms. Birenbaum, you're familiar with the organization called Dying With Dignity, which is an advocacy group for those who wish to access MAID. Is that correct?

Ms. Shelley Birenbaum: Yes, I'm familiar with it.

Hon. Ed Fast: Are you a legal adviser to them?

Ms. Shelley Birenbaum: No. I'm a volunteer. I've sometimes been asked some questions and I've spoken with them.

Hon. Ed Fast: Have you given them legal advice in the past?

Ms. Shelley Birenbaum: I've given them legal advice, yes.

Hon. Ed Fast: Thank you.

Have you served as an ambassador for Dying With Dignity?

Ms. Shelley Birenbaum: I don't know what it means to be an ambassador. I have previously worked with them directly.

Hon. Ed Fast: All right. Thank you.

Have you polled or surveyed your members to determine whether they feel Canada is ready to implement MAID for the mentally ill?

Ms. Shelley Birenbaum: We haven't polled our members on whether there is a state of readiness, but our positioning is based on resolutions adopted by the membership of the Canadian Bar Association, including that MAID be available for persons who have mental illness. There are resolutions that, at their point of adoption, were 100% in favour, but we have not specifically looked at readiness, no. We have not done a resolution on readiness.

Hon. Ed Fast: Is there any consensus within the legal profession on whether the Charter of Rights compels government to make MAID available to the mentally ill?

Ms. Shelley Birenbaum: I can only say that all members of the end of life working group who have been looking at these issues have come out with the positioning that there is a strong charter vulnerability to say that every single mentally ill person will not have access to even be determined for eligibility for MAID.

Hon. Ed Fast: You can probably agree, since we're both lawyers, that lawyers can often disagree among themselves. Is that correct?

Ms. Shelley Birenbaum: Absolutely lawyers can disagree among themselves.

Hon. Ed Fast: We don't know what the Supreme Court of Canada would say when it comes to requiring government to expand MAID to include the mentally ill. Is that correct?

Ms. Shelley Birenbaum: We don't know what the Supreme Court of Canada would say. However, the CBA has taken the position that Carter did not exclude mentally ill persons, and—

Hon. Ed Fast: It did not require mentally ill persons to be included either, did it?

Ms. Shelley Birenbaum: That is correct. It didn't say "thou must"—

Hon. Ed Fast: I'm stating the obvious when I say that this is about life and death. Wouldn't it be more appropriate to have the federal government send this to the Supreme Court by way of reference rather than gambling on the lives of the mentally ill?

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

I'm sorry about the time. I went—

Hon. Ed Fast: Can I have just a quick yes or no?

The Joint Chair (Hon. Yonah Martin): Let's get a yes or no.

Ms. Shelley Birenbaum: The CBA has not considered this. In my own view in thinking about this, given our thoughts about vulnerability, I don't think, in this sense, that the group would feel this way, but we would have to check.

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

Next we will go to Mr. Fisher for three minutes.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Madam Chair.

I want to thank our witnesses for being here. We have such a narrow mandate that you'll be hearing, and are already hearing, a bit of repetition and a bit of different phrasing of some of the questions. The narrow mandate, of course, is just to verify the degree of preparedness attained for a safe and adequate application of MAID.

I've always supported MAID. Every time there was a MAID vote, I voted for it. I support the safeguards and I certainly support the Charter of Rights.

Dr. Freeland, your organization takes no position, but perhaps I can ask you this as an individual: Do you think the health system is ready for an expansion of MAID eligibility for individuals whose sole underlying medical condition is a mental disorder?

Dr. Alison Freeland: Thank you for that question. I'm just reflecting on it as an individual.

I work in Ontario, which is a complicated province. There are lots of different health care systems there. I think there is still work to be done at a local level to ensure that the entire system has created a coordinated point of access.

The encouraging thing is that where I am, there is now a provincial group looking at a community of practice around medical assistance in dying, particularly for a mental disorder. In Toronto, where I work, we now have a coordinated working group sponsored by the two local Toronto hospitals, which, again, is turning its mind to how to do this. It is represented by a number of different health professionals and includes psychiatry. In fact, the Toronto working group is co-chaired by two psychiatrists.

I think people are working hard knowing that there is a date in mind to get to a place of readiness and knowing that readiness is never going to be perfect. When we think about readiness in this context compared to when MAID came out way back with Bill C-14, there's been a lot more work done on the national approach around standards and available curriculum, and I think many different organizations are engaging health care teams around how to best understand this.

I am definitely not a MAID expansionist. I just truly believe that it's very stigmatizing—and this is my personal belief—to take a group of patients and say to them, “You can't even be considered for something because you have a mental illness.”

I believe that very few people would be found eligible should this go ahead with respect to mental illness. Ms. Birenbaum has clearly outlined all of the safeguards and processes we'd have to get through to get to that point.

Those would be my personal reflections, not the CPA's reflections.

● (1925)

The Joint Chair (Hon. Yonah Martin): There are five seconds remaining.

Mr. Darren Fisher: I won't need them.

The Joint Chair (Hon. Yonah Martin): All right, thank you.

We'll go next to Mr. Thériault for two minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

A number of people who talk about mental disorders as the sole underlying medical conditions claim that people who are suicidal and in crisis or are depressed could have access to medical assistance in dying, whereas nothing in the expert report says that. In fact, it says the opposite.

My question is for both witnesses. I would ask them to give a brief answer.

Do you think that expanding medical assistance in dying to people with mental disorders could have a preventive effect in suicidal individuals?

For example, if a suicidal person, the day after the amended act is passed, raises their hand and says that they want to have access to medical assistance in dying, at least we will know that they need help and can be taken care of when, at the moment, they are completely abandoned and could make attempt suicide.

Isn't this a preventive measure?

[*English*]

Dr. Alison Freeland: Was that directed to me?

The Joint Chair (Hon. Yonah Martin): Yes, Dr. Freeland.

Dr. Alison Freeland: That's a great question, and I think there is a lot of debate about that.

First of all, I think if we were all living in a perfect health care system, we would assume that people have quick access to an assessment at the onset of suicidality and would ensure they have rapid access to treatment and care in the system. I think that's something we all strive for broadly in the health care system.

With respect to people accessing an expert assessment because of an ask around medical assistance in dying, I think there has been some debate about the fact that, when you see a psychiatrist and are able to explore your illness and understand diagnosis and treatment options, many people who get to that stage may in fact not be eligible.

Again, I'm going to put my personal hat on. One of the important parts about readiness—and it's something we've talked about in Ontario—is the navigation back into the health care system. When you look at the standards, there is a requirement to continue to provide ongoing treatment and care for people who are not found eligible for MAID. In this context, there is that opportunity.

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

Mr. Angus, you have two minutes.

Mr. Charlie Angus: Thank you, Dr. Freeland.

I want to go back to the question of whether we're ready for March 2024. You said that Canada had decided we were going down this road. I would say that the Senate, which is not elected, threw in a date and told us to live with it, and the Liberal government agreed. That date was March 2023. As it approached, they panicked, so now it's March 2024.

This is a huge Rubicon we're crossing, so what's more important? Is it the date or getting it right? Would you suggest that we take the time to do this right? If it's proven that it's not going to affect a lot of people and that there are going to be all these safeguards, do we need to meet the arbitrary date that was put in between the Liberal government and the Senate, or should we do this in light of the bigger and broader consensus that we need to achieve to make sure people are protected?

● (1930)

Dr. Alison Freeland: That's a difficult question to answer, because we are still five months away, and the rate of activity to get ready continues to accelerate. We continue to see people engaging around this, and systems of care are beginning to evolve around it. That's where it's challenging to say whether we're going to be ready against the date that has been selected.

It's already been put off once, and I think there has been substantive work done, but—

Mr. Charlie Angus: This isn't like opening a business; these are people's lives and deaths right now. Things may be moving fast, but given the huge disparities in health across this country—and this country is very large—there are huge differences. Yes, things may be moving fast, but can I go back and reassure people?

People call me about this. This is an issue people are deeply concerned about, because they have loved ones who have deep, dark mental illnesses they cannot get treatment for because treatment doesn't exist. It's the date that matters.

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

We are at 7:30 and need to get ready for our second panel.

Thank you to our witnesses this evening for taking our questions.

● (1930)

_____(Pause)_____

● (1935)

[*Translation*]

The Joint Chair (Mr. René Arseneault): We're back.

I would like to make a few comments for the benefit of the new witnesses.

Before speaking, please wait until the chair recognizes you by name. A reminder that all comments should be addressed through the chair. When speaking, please speak slowly and clearly. I would ask those in the room to speak very close to their microphones in order to help the interpreters.

Interpretation in this video conference will work like in an in-person committee meeting. For those participating by video conference, you have the choice, at the bottom of your screen, of floor, English or French. When you are not speaking, please keep your microphone on mute.

I would now like to welcome the witnesses for the second panel. Joining us by video conference, we have Dr. Mona Gupta, psychiatrist and researcher at the Centre hospitalier de l'Université de Montréal.

[*English*]

I welcome Dr. Douglas Grant, representing the Federation of Medical Regulatory Authorities of Canada.

● (1940)

[*Translation*]

Lastly, we have Dr. Claire Gamache, psychiatrist and president of the Association des médecins psychiatres du Québec.

Thank you all for being with us today.

I'll now give the floor to the joint co-chair, Senator Martin.

[*English*]

The Joint Chair (Hon. Yonah Martin): Thank you to our witnesses. We will begin with opening remarks by Dr. Gupta, followed by Dr. Grant and Dr. Gamache.

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

Dr. Mona Gupta (Psychiatrist and Researcher, Centre hospitalier de l'Université de Montréal, As an Individual): Thank you very much, Madam Chair, and thank you, all, for the invitation to meet with you today.

I'm a psychiatrist and bioethics researcher at the University of Montreal. I've had the opportunity and the privilege to be closely involved in the public conversation about assisted dying for persons with mental disorders as their sole underlying medical condition—MDSUMC for the rest of my remarks—since its beginning.

I served as a member of the CCA working group on MAID for MDSUMC mandated by Bill C-14. I chaired the federal expert panel on MAID and mental illness, mandated by Bill C-7. More recently, I led the work of Health Canada's MAID practice standards task group, and I also led the working group that developed CAMAP's educational module for MAID and mental disorders.

It is from this vantage point that I want to share some observations about readiness.

When the Government of Canada made the decision to include persons with mental disorders as their sole underlying medical condition on equal terms with all other medically ill suffering persons whose natural deaths were not reasonably foreseeable, it committed to do three things: constitute an expert panel on MAID and mental illness, strike a special joint parliamentary committee to further study the matter, and revise its data collection system. As we know, the federal government has fulfilled these commitments.

When the federal government made the decision to extend the exclusion for an additional year, it spoke about the need for extra time to ensure that two major deliverables—the CAMAP MAID curriculum and the model practice standard for MAID—were complete. As we know, these activities are complete. The standard has been in the hands of physicians and nurse regulators since April of this year, and they are adopting or adapting the standard as appropriate within their jurisdiction. The CAMAP MAID curriculum was launched in September 2023 and has been offered already, numerous times, to physicians and nurse practitioners.

Several other initiatives have occurred since December 2022, including a national MAID MDSUMC preparatory workshop with delegates from every province and territory, including MAID assessors, providers and psychiatrists. There has also been a national system readiness workshop to share knowledge about administrative processes.

Most provinces and territories are working with frontline clinicians, regulators and administrative authorities to ensure that clinical processes are appropriately tailored for requesters with mental disorders. I have provided several examples of these activities in my brief.

A few weeks ago, I taught the CAMAP MAID and mental disorders module to a group of about 20 psychiatrists, family physicians and nurse practitioners in Vancouver. Beforehand, the colleague co-leading the session, an experienced family physician and MAID assessor and provider, Dr. Tanja Daws, bounded up to me. Even though MAID MDSUMC is not allowed, she said, I've already had patients with all the same types of issues in the case studies we cover in the module.

What struck me about Dr. Daws' comment is that persons with mental disorders as their sole underlying condition who make requests for MAID will be in the careful hands of experienced clinicians who, over these last seven years, have already handled the full range of complexities in their MAID practice that MDSUMC requests may present. Her comment also confirms what the expert panel concluded, that the complexities so often attributed to mental disorders are not, in fact, unique to mental disorders and are already being handled in our MAID system today.

The work that has been undertaken on MAID MDSUMC since 2017 has been thorough, the processes transparent and collaborative. The Government of Canada has fulfilled every commitment concerning readiness that it made. It has also made unprecedented contributions to health care professional education and regulation, which well exceed the scope of its jurisdictional responsibilities.

As my colleagues Dr. Gamache and Dr. Grant know better than I, the other essential actors in health care and in the MAID system—regulators and professional associations—have been active concerning MAID since 2015. They will continue to fulfill their mandates. In the case of the regulators, this is guiding clinicians towards safe MAID practice in the public interest, and in the case of professional associations, ensuring their members are equipped to participate in MAID if they choose to do so.

By far, more thought, care and capacity building have been done for persons with mental disorders as their sole underlying medical condition than for any others. This is a good thing, and this work will have the added benefit of strengthening Canada's MAID system for all patients.

If you were to ask me what I need if tomorrow I had to assess MAID eligibility for a person with a mental disorder as their sole underlying medical condition, the answer is nothing. The work has been done. We are ready.

● (1945)

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

Next, we will have Dr. Grant for five minutes.

Dr. Douglas Grant (Registrar and Chief Executive Officer, College of Physicians and Surgeons of Nova Scotia and Representative, Federation of Medical Regulatory Authorities of Canada): Thank you. It's a privilege to speak to the committee.

I'm Dr. Douglas Grant. I'm a registrar of the college of physicians in Nova Scotia. I'm a family doc and a lawyer, and I represented the Federation of Medical Regulatory Authorities of Canada at the Health Canada working group.

My approach to the question is that all readiness must be built on regulatory readiness. My respectful submission is bluntly this: Regulators are ready for this. We don't need any more time. We're not coming for more time.

We will be ready for many reasons.

The first is that most of the hard work has been done. The model practice standard developed by the Health Canada working group is the best synthesis of the law with the input of all necessary stakeholder voices. I know I speak on behalf of my fellow registrars that we see these as very useful documents. The document can be adopted in whole, which Nova Scotia will do—and I can tell you that we will be adopting it in whole in other Atlantic provinces as well—or used as a template to build a professional standard upon. The supporting documents provide à la carte language that could be plugged into existing college standards.

At the end of the day, what will happen in March 2024 is that all medical regulators will have guidance and professional standards in place that are built from or informed by the model practice standard developed by the Health Canada working group. With exceptions for style and format, there will be substantial consistency between provinces.

The second reason why the regulators will be ready in March is that we have a solemn and legal duty to be ready.

There may be some slight variations in provincial legislation, but all medical regulatory colleges have a mandate to regulate the medical profession in the public interest. That mandate means we're in service to patients. In this case, we're in service to the specific patients who are suffering, who are being denied a form of care to which they are entitled in law, and who, as a class, have been suffering and denied this care since 2015.

Finally, our duty extends to physicians themselves who look to provide this care, who are entitled to a clear articulation of regulatory direction and expectations. I'm here to say that the regulators will meet their duties.

The fact that we're here implies that you have heard voices from non-regulators implying that the regulators are not ready. I would like to unpack those concerns.

First of all, they are not supported by history. At each step of MAID's evolution, there has been a chorus of voices asking whether the regulators were ready. After the one-year implementation period was coming to an end following Carter, there were calls of unreadiness. At the time, I was the president of the Federation of Medical Regulatory Authorities of Canada, and I made submissions to a joint committee like this—I don't think it was in this room—indicating that the regulators were ready. We were ready.

We were ready when the law evolved to include eligibility for patients whose natural death was not reasonably foreseeable. Then we were ready again when Audrey's amendment, which enabled a waiver of final consent to eligible patients at risk of a loss of capacity, came into law.

I guess I would like to say that this is par for the course. Medicine constantly evolves. MAID will evolve and the medical regulators will respond, because we have a duty to be nimble.

I hope that the concerns of unreadiness are not in response to silence on the websites of colleges like my own. That would be a mistake. Professional standards serve many purposes. They declare the regulatory expectations, direct the caregivers, and also serve a public purpose. They advise the public of what it is entitled to expect. Rooms like this indicate that the situation is fluid. The regulators in the college in Nova Scotia, which I run, will wait until the path forward is settled and political debate has stopped. The medical regulators have no desire to mislead or confuse the public.

I would encourage this committee to be disciplined in its efforts to distinguish opposition to MAID from accusations of unreadiness. In my experience, the choir of voices making accusations of unreadiness has been entirely composed of voices that are opposed to MAID. With the courts having made their final decision, opposing voices cannot advance arguments to stop MAID.

● (1950)

I would ask the committee to ask whether the accusations of unreadiness are a genuine argument or simply an attempt to buy time for the sake of time, when no time is needed—at least not from the regulatory perspective.

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

Lastly, we'll have Dr. Gamache for five minutes.

[*Translation*]

Dr. Claire Gamache (Psychiatrist, Association des médecins psychiatres du Québec): Good morning, everyone.

My name is Dr. Claire Gamache. I'm the president of the Association des médecins psychiatres du Québec.

We thank the House of Commons for the invitation and the opportunity to discuss these sensitive issues.

The Association des médecins psychiatres du Québec, or AMPQ, is one of the 35 associations affiliated with the FMSQ, the Fédération des médecins spécialistes du Québec, which represents 1,200 psychiatrists.

The association is a union that strives for optimal conditions of practice for its members, but since its inception, the association has been interested in the organization of care, access to mental health services, and the improvement of public literacy on mental disorders.

From the outset of the discussions on medical assistance in dying when mental disorders are the sole underlying medical condition, the AMPQ was involved and took part in the conversation.

We participated in the Standing Committee on Justice and Human Rights' consultations on Bill C-7, the presentation of the position statement of the Collège des médecins du Québec in October 2020, the presentation to the Commission on end-of-life care of the AMPQ's discussion paper entitled “Access to medical assistance in dying for people with mental disorders”, at the national forum on the evolution of the Act respecting end-of-life care, and the consultations of the Special Commission on the Evolution of the Act respecting end-of-life care.

In 2020, the AMPQ's board of directors approved the position that people whose sole underlying medical condition is a mental disorder should not be systematically excluded from medical assistance in dying.

At the request of the Collège des médecins du Québec and the Commission sur les soins de fin de vie, the AMPQ published a discussion paper including a proposal on how medical assistance in dying could be organized within the province of Quebec. That brief was produced with the input of a patient partner and a member representing caregivers.

The AMPQ presented its work to its members at its annual meeting in 2021.

To educate its members, the AMPQ offers continuing professional development activities at its annual conferences and a day of update on medical assistance in dying for medical specialists in Quebec. That day will be held on November 17, 2023, with a session specifically on mental disorder as the sole underlying medical condition.

The AMPQ testified before the parliamentary committee responsible for studying Bill 11 in Quebec. During its testimony, the AMPQ advised the government not to include an exclusion clause for persons with mental disorders. A number of professional associations, including the Fédération des médecins spécialistes du Québec, the Fédération des médecins omnipraticiens du Québec and a number of regulatory bodies, including the Collège des médecins du Québec, the Ordre des psychologues du Québec, the Ordre des infirmières et infirmiers du Québec, and the Ordre des travailleurs sociaux et des thérapeutes conjugale et familiale du Québec, as well as the Commission des droits de la personne et des droits de la jeunesse du Québec, have expressed a similar opinion to that of the AMPQ.

In addition to its regular activities, the AMPQ sat on the national steering committee of the Canadian Association of MAiD Assessors and Providers and reviewed the program as a whole.

All of the AMPQ's interventions and participation in the conversation surrounding medical assistance in dying are intended to raise awareness of the reality of people with mental disorders, their loved ones and the caregivers who support them.

Our experience shows that mental disorders remain little-known and that their effects on life courses are poorly understood by the public.

When we talk about MAID when mental disorder is the sole underlying medical condition, we're talking about patients who we've been following for decades who have tried multiple therapies and treatments.

As you heard from Dr. Gupta, psychiatrists on the ground are already involved in assessing, in various forms, a complex clientele in the MAID processes. They participate in second assessments, collaborative assessments with GPs, and as in any new care, there will be graduated skills development through pairing, mentoring, and training.

The main objective of the AMPQ is to combat stigma by using its expertise and experience with the most vulnerable. However, to avoid perpetuating this stigma and discrimination, inclusion is the best option.

● (1955)

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

[*English*]

We will now go into our first round. For this panel, I think we're only going to get through one round for each of the MPs and the senators.

We'll begin with questions from Mr. Cooper.

You have five minutes.

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

My questions are for Dr. Gupta.

Dr. Gupta, you said we're ready with respect to MAID and mental illness. I would submit that's tough to accept, given what we've heard in the previous hour about how there's no consensus among psychiatrists. Only 2% of psychiatrists have signed up for the curriculum program, and there aren't enough resources, but you say we're ready. Are we, really?

I would submit that the heart of the issue is the question of irremediability—whether someone can get better and whether that can be accurately predicted. As you will recall, on page 40 of the expert report issued by the panel you chaired, it states that:

> There is limited knowledge about the long-term prognosis for many conditions, and it is difficult, if not impossible, for clinicians to make accurate predictions about the future for an individual patient. The evolution of an individual's mental disorder cannot be predicted as it can for certain types of cancers.

That report was issued in May 2022. Has anything changed since May 2022 with respect to that conclusion?

Dr. Mona Gupta: If your question is whether there is something different about mental disorders compared to other conditions for which someone can currently access assisted dying, then, no, that hasn't changed since May 2022. That was exactly the point the panel was making: Yes, there are these difficulties, but these difficulties exist in track two as well. If track two can go forward and people can be afforded appropriate protections under track two, the same can occur for mental disorders.

Mr. Michael Cooper: It's not just a challenge; it's a Criminal Code prerequisite in order to qualify for MAID. What you have said—and you confirmed it tonight—is that it is difficult, if not impossible, to predict. We heard testimony from experts when this committee last convened, including from Dr. Mark Sinyor, who said that the error rate for predicting irremediability could be anywhere from 2% to 95%. In other words, we're flying blind.

In the face of that, how can you say we're ready?

Dr. Mona Gupta: Well, I can say we're ready because we are doing these kinds of eligibility assessments for all kinds of complex patients, including patients who have comorbid mental disorders, in which the mental disorder may play a significant role in motivating the request. There are many medical conditions for which prognostication is “difficult, if not impossible”, to borrow the same language of the expert panel report, and yet we reason clinically about these cases in full respect of the Criminal Code requirements. As you know, no physician has been prosecuted and not a single successful college complaint has been made. Physicians and nurse practitioners are using these criteria to reason about cases when people have had, as my colleague Dr. Gamache said, very long histories of treatment—

Mr. Michael Cooper: With respect, Dr. Gupta, I've given you some time to answer, and I think you've made my point—that we're not ready, not in the face of that.

Would you agree that suicidality is often a symptom of mental illness?

Dr. Mona Gupta: I would say it is one of the criteria of a small number of specific conditions.

Mr. Michael Cooper: Page 7 of Health Canada's “Advice to the Profession: Medical Assistance in Dying”, which you helped write, states, “MAID eligibility assessments must not be undertaken in circumstances of acute suicidality.” What about in cases of chronic suicidality? Why is that missing from your advice to the profession?

● (2000)

Dr. Mona Gupta: It is precisely because some people with mental disorders—a very small number, I think—are going to be able to make a capable, informed decision to access MAID despite the fact that they may have also struggled with suicidal thinking over the course of their lives. This is already the case, because people who may have struggled with suicidal thinking over the course of their lives make MAID requests now.

Mr. Michael Cooper: How much time do I have?

The Joint Chair (Hon. Yonah Martin): You have 15 seconds.

Mr. Michael Cooper: Okay.

Thank you.

The Joint Chair (Hon. Yonah Martin): Ms. Koutrakis, go ahead.

Ms. Annie Koutrakis (Vimy, Lib.): Thank you, Madam Chair.

Thank you to our witnesses for being here with us this evening.

I'm going to start my questions with Dr. Grant.

I wonder if you can confirm for us, please, whether you are speaking tonight on behalf of the Federation of Medical Regulatory Authorities of Canada or the College of Physicians and Surgeons of Nova Scotia, or if you're here as an individual.

Dr. Douglas Grant: I was invited here as the Federation of Medical Regulatory Authorities of Canada representative on the Health Canada working group.

Ms. Annie Koutrakis: That's great.

Would you be able to please explain how the MAID practice standards task group's guidance on MAID eligibility assessments differs from what has been practised up to this point? My understanding is that you were a co-chair of that group.

Dr. Douglas Grant: Actually, the invitation said I was a co-chair and I wasn't, so I don't want to.... I was just a member of the group.

Ms. Annie Koutrakis: Thank you for clarifying that.

Dr. Douglas Grant: Your question is how the model standard put forward by the working group differ from what's in practice right now.

Ms. Annie Koutrakis: Yes.

Dr. Douglas Grant: It contemplates the inclusion of people whose sole underlying medical condition is a mental disorder. It also unpacks—and I think Dr. Gupta was getting into that—some of the more difficult cases. It gives guidance on some of the more difficult cases in what are track two cases, where one's natural death is not reasonably foreseeable.

Ms. Annie Koutrakis: What was the basis for including a different approach to MAID eligibility assessments? I wonder if you can go a bit deeper.

Dr. Douglas Grant: After the Carter decision.... I think most people who work in my space interpret Carter as not excluding people whose sole underlying medical condition was mental illness, who could be eligible. We were then responding to a number of changes in the law and changes in direction from Parliament.

The mandate came from Health Canada to this working group to provide clarity to the professions and the providers—not just the medical regulators, but nurse regulators—to provide a document of direction for the professions involved.

Ms. Annie Koutrakis: Dr. Gupta, you very clearly stated that the system is ready. What have you heard from medical practitioners about whether they feel equipped, and how they feel they are equipped, to undertake assessments, provisions and consultations for MAID where mental illness is the sole underlying condition?

Dr. Mona Gupta: There's a full range of experience, just like there is for MAID now. There are some people who are actively involved. There are some people who are not involved. There are some people who are occasionally involved. I would say the same thing is true for psychiatrists.

As with any new and complex practice—and this is true for everything that we do in medicine—people who are less experienced aren't the people who are going to start. The people who are going to start are people like my colleague Dr. Daws, whom I mentioned in my opening remarks. They have a lot of experience and have seen a lot of patients, and they're the ones who are going to do the initial work while, as Dr. Gamache said, they train and mentor others who wish to become involved.

There will always be people who don't want to be involved, and that is completely fine. The colleges and the law allow for that.

It's interesting that we're talking about the 2%, because, in fact, only 2% of Canadian physicians are MAID providers, so it's a small number of people who wish to be involved. Those people will continue to be involved, some more than others. That's entirely normal.

Ms. Annie Koutrakis: Dr. Gupta, do you think systems of MAID oversight and quality assurance are adequate across Canada? If so, how?

Dr. Mona Gupta: Oversight, of course, as you know, is a provincial and territorial responsibility. There are differences between provinces and territories in the mechanisms that they choose to deploy for oversight, from Quebec's Commission sur les soins de fin de vie, which is very formal, to coroners' reviews and ministry oversight committees.

What I can say is that 90% of MAID cases are occurring in jurisdictions with formal oversight processes. One of the benefits of the extra work that has been done—and this is what I meant in my opening remarks—is that those provinces and territories that have less formal mechanisms are working on building more formal mechanisms. This work is actually going to benefit all patients, not just patients with mental disorders.

● (2005)

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

Next, we'll have Mr. Thériault, for five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

I want to thank the witnesses for their clear testimony.

Dr. Gamache, I asked the same question earlier, but I don't know if it was understood.

Do you think that expanding access to medical assistance in dying to people with mental disorders could have a preventive effect on those who, for example, have suicidal ideation and are not currently in care? Would expanding this access allow these people, who may want to request medical assistance in dying, to be taken care of? At the moment, we don't know that they need help.

Dr. Claire Gamache: I believe so. Patients are already arriving at the emergency room and requesting medical assistance in dying because of physical problems or significant psychological distress, which triggers a whole process that means they are taken care of more quickly since there are delays in obtaining a response to a medical assistance in dying request.

I would go even further: discussing this request with our patients is part of a therapeutic process that can be very healthy for patients with mental disorders.

Mr. Luc Thériault: You've told us that an impressive number of health care professional organizations have recommended this expansion.

How do you explain the fact that the Quebec National Assembly didn't want to move forward? I would ask you to keep your answer as brief as possible.

Dr. Claire Gamache: I think it's a matter of social acceptance.

Stigma is everywhere and, unfortunately, it's also in the legislation, in my opinion. We will have to think about how we treat this clientele, which is part of the entire health care process. We have to ask ourselves why it takes so long in the case of mental disorders. Why are these people being treated differently? As has been mentioned a number of times, the track 2 assessments are already very complex, and mental disorders can very well be part of those assessments.

Mr. Luc Thériault: One of our concerns has to do with preparing people on the ground.

Does the fact that the Government of Quebec has decided not to move forward create a barrier in terms of clinical practice and preparation on the ground in Quebec? If Quebec's Commission on end-of-life care specifies that, legally speaking, the most repressive or harsh legislation must be complied with, how will that work? How are practitioners going to feel?

Dr. Claire Gamache: Practitioners will indeed feel caught between two acts.

That said, we have been experiencing discord for a few years in a number of respects. Doctors will certainly respect the requests of the Quebec Ministry of Health and Social Services and the recommendations of the CEOs.

We'll comply, but we'll have to tell our patients, some of whom are already asking us for medical assistance in dying, that they'll have to wait until it's permitted and that the choice has been different in Canada.

Mr. Luc Thériault: Will they have to wait until it is allowed by the Criminal Code or by Quebec?

Dr. Claire Gamache: Well, in Quebec, it probably won't be allowed in the health care organization.

In Quebec, medical assistance in dying is health care. If the ministry of health and the Government of Quebec tell us that this type of care cannot be provided, hospitals and organizations won't be able to provide it.

Mr. Luc Thériault: Dr. Gupta, you said we're ready.

Have enough people received the necessary training to proceed with medical assistance in dying soon, as in, by March 2024?

● (2010)

[*English*]

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

[*Translation*]

Dr. Mona Gupta: I think so.

I think we have to distinguish between the psychiatrist who acts as a consultant and the psychiatrist who acts as the assessor. Psychiatrists already participate as consultants with the two physicians or two specialized nurse practitioners. They do assessments. This is already being done. Psychiatrists in that role already have the necessary skills. There are also psychiatrists who do assessments, and there will be more and more of them thanks to the training that's now in place.

[*English*]

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

Last, I will go to Mr. Angus, for five minutes.

Mr. Charlie Angus: Thank you.

Thank you, doctors, for your great expertise.

It has been suggested that some of us who were raising questions about being ready want to relitigate MAID. I'm not one of them. I've had some very close friends choose MAID so they could have an end of life that they had control over with their families. These were very profound moments. I respect that. I'm trying to see how.... I deal with families, with people who have deep mental illness and depression. How can I assure them that this process is done with all the care necessary?

Dr. Gamache, you said that those who would be eligible would have been involved in the medical community for decades. If someone comes in with deep and significant suffering, deep depression, perhaps addiction and suicidal ideation, but hasn't been involved for decades, would they still be eligible?

[*Translation*]

Dr. Claire Gamache: I don't think so, not if they can't access treatment. As Dr. Gupta said, people are discriminated against in two ways: first, they may not have access to treatment; and, second, they won't get access to MAID.

There has to be a significant record of treatment attempts, and they'll have to have had the time to have an exhaustive conversation with the patients. Then they can reach that conclusion, as they would for someone with a major physical problem.

However, if people don't have access to services, I don't think they can access MAID. That's very clear the way track two is currently laid out.

[*English*]

Mr. Charlie Angus: Thank you for that.

I'm trying to get my head around this issue of discrimination against the right to MAID, or discrimination against the right to proper medical treatment.

Dr. Gupta, you said the federal government had stepped up above and beyond in making sure of everything that was necessary. In the work that I do as a member of Parliament, we're screaming for the federal government to step up all the time on mental health, but it doesn't.

I represent northern rural communities that are isolated, where we have suicide deaths from gunshots. We have people with deep mental illness who just run off into the woods, and the family can't find them. I'm having a problem here with saying that we're ready to have a really clinical, clear process for people to end their lives, but we don't have the tools in place to be ready to keep people through these times of crisis.

You're on the front line. What do you see?

Dr. Mona Gupta: I think we can all agree. Whatever views we have about MAID for persons with mental disorders, we can all agree that mental health services and addictions services in this country could stand to be improved, and there could be much greater access.

I think what Dr. Gamache is pointing out is that these unfortunate souls who do not have proper access to care will not be eligible for MAID anyway.

Mr. Charlie Angus: I appreciate that. I don't know anything about medicine. I dropped out of high school to play in a punk band. My life experience is dealing with families in crisis. That's what I do as a member of Parliament. We deal with this all the time.

It is a very emotional issue for people. I have a really hard time going back to them and saying “Don't worry; there will be a process for MAID” but not being able to tell them there will be a process for their loved one to get treatment.

Who is eligible, and who is not? If it's deep depression, I know people who have had deep depression for years. I know people who have been deeply suicidal for years. I'm reading all the clinical reports on how they should be treated and how they should assessed. To me, it doesn't sound like the real world. It sounds like an ideal situation of someone who sought this, who comes through the door and has made an informed decision. We're dealing with people who live in storms of darkness and upheaval, and then they settle down and their families go with them.

What are the provisions that separate that?

● (2015)

Dr. Mona Gupta: Is that for me or for Dr. Gamache?

Mr. Charlie Angus: It is for either one.

The Joint Chair (Hon. Yonah Martin): You have 30 seconds. Answer very briefly, please.

[*Translation*]

Dr. Claire Gamache: We may observe tremendous distress in the people close to us, but it's true that, in the psychiatrist's office, distress looks different. There's a lot of analysis and assessment. People don't ask friends, colleagues or MPs for MAID; they ask the physician who's been treating them for a long time and who has looked at the treatment options with them.

That's part of my answer.

[*English*]

The Joint Chair (Hon. Yonah Martin): Thank you to all our witnesses.

We will go now to questions from the senators.

[*Translation*]

The Joint Chair (Mr. René Arseneault): Senator Mégie, you have three minutes.

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

My question is for Dr. Gupta and Dr. Gamache, and I'd like brief answers.

Last year, a psychiatrist appeared before our committee. On the subject of an individual's eligibility for MAID, she said there were so many important criteria to consider that, out of all the cases she had seen in 30 years of practice, she had encountered only three people who were eligible, given the long-term treatment, chronic disease, and so on.

What are your thoughts on that?

Dr. Mona Gupta: I agree. I would say more or less the same thing. In 23 years, I've encountered maybe two people who would meet the criteria.

Dr. Claire Gamache: I'd say the same.

Hon. Marie-Françoise Mégie: Thank you.

I think what I've been hearing is that, until all psychiatrists have the training to participate in MAID, we won't be ready. However, there are lots of family physicians and health professionals, and they don't all participate.

What are your thoughts on that as far as psychiatrists go? We don't need them all to have the training before we can proceed, do we?

Dr. Mona Gupta: As I said, it's been seven years, and only 2% of all physicians in Canada assess certain patients' eligibility for MAID and deliver it.

We need a small number of people who are prepared to work with a small number of patients. Of course not everyone in the medical professions will have the same level of training and be up to date on all practices. People specialize and work with specific clients. That's normal.

There's no such thing as a practice that everyone has the same level of training and upgrading for.

Hon. Marie-Françoise Mégie: Thank you.

Thank you, Mr. Chair.

The Joint Chair (Mr. René Arseneault): Thank you, Senator Mégie.

[*English*]

Next is Senator Kutcher for two minutes.

Hon. Stanley Kutcher: Thank you, Chair.

Just before I ask the question, can we ask Dr. Freeland to give us the two papers she referred to in her testimony for us to look at? Maybe the clerk could ask for them.

Dr. Gupta, there seems to be a bit of confusion between providing treatment for mental illness and providing MAID. If a patient wants treatment, would they actually be eligible to receive MAID?

Dr. Mona Gupta: No.

Hon. Stanley Kutcher: Okay. I think that's clear. Thank you.

The other part here is that there seems to be confusion between assessors and consultants. More psychiatrists are taking on the training to become assessors, but we already have psychiatrists who are consultants around MAID. We expect that the number of people seeking MAID for mental illness will be very small.

Do we actually have enough people in the profession who could provide the consultation that is needed and, as the profession grows and develops, will more become assessors as well? I think there's confusion between the two.

Dr. Mona Gupta: I know that I personally have never been involved in or aware of any case where a psychiatric consultant was needed to support assessors and it was not possible to obtain a psychiatric consultation. Dr. Gamache has a view of the entire province of Quebec and can probably comment on that better than I can.

That's correct. We're already doing that work as consultants, as the safeguards, the persons with expertise, and we will continue to do that work. I think people are becoming more and more interested as time passes in becoming assessors, and they are doing training and are learning from their already experienced colleagues how to do that work as well.

● (2020)

Hon. Stanley Kutcher: There have been some psychiatrists who are opposed to the whole concept of readiness. Have any of your colleagues ever participated in any of the work to develop readiness criteria? Have they asked to participate or is there a perspective that readiness will never exist and therefore why participate in discussing readiness?

Dr. Mona Gupta: I'm not inside their minds, so I can't tell you what they're thinking, but I'm really glad you brought that up, because I think some of the voices that are saying we are not ready have contributed nothing to becoming ready.

I would submit that one way of assessing whether somebody is sincere about concerns about readiness—as opposed to, as Dr. Grant said, using that as a way to express opposition—is to see what they have contributed towards becoming ready. Somebody who is sincerely concerned about readiness is going to get involved. Those voices have not been involved even when opportunities have clearly been presented to them.

Hon. Stanley Kutcher: You have a sacred duty here as regulators. Would regulators agree to allow the practice of MAID if the proper standards for the practice of MAID were not in place?

Dr. Douglas Grant: No.

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Grant.

That's all for this moment, Mr. Kutcher.

[*Translation*]

Senator Dalphond, you have three minutes.

Hon. Pierre Dalphond: I want to thank the three witnesses for participating in our meeting.

Dr. Gamache, you said that the board of directors of the Association des médecins psychiatres du Québec approved your organization's position on MAID and that it was put to the annual assembly in 2021.

Would it be accurate to say that you speak on behalf of an organization that consulted its entire membership?

Dr. Claire Gamache: It was presented at the annual assembly. There was no vote on it, but it was presented to all of our members.

We will continue to work with all of those people.

Hon. Pierre Dalphond: You're also of the opinion that psychiatrists have enough training to avoid making mistakes.

Dr. Claire Gamache: We're already trained for track two.

It's exactly the same track for patients with mental illness.

[*English*]

Hon. Pierre Dalphond: My next question is for Dr. Grant.

You said the regulators are ready and we don't need more preparation. Does this mean that because you're ready as regulators, the practitioners are ready to go forward?

Dr. Douglas Grant: I would say the practitioners couldn't go forward without the regulators being ready. The regulators will have built on the working group's work. We've all developed the documents.

The regulators will all have direction in place, so that the practitioners—the physicians—will know what's expected of them. More importantly, or as importantly, because our standards face forward, the public will know what they're entitled to.

Hon. Pierre Dalphond: You say this is the case for the 10 provinces and the three territories.

Dr. Douglas Grant: I can say that the model practice standard that we've developed has been shared with all of the colleges. They've all welcomed it. I've spoken with each of the registrars, who will all use this document in one way or another to have their provincial standard in place.

Hon. Pierre Dalphond: Has each province made it their standard, or is it in the process of being made the standard?

Dr. Douglas Grant: They will be using this document either to inform their standard or to build their standard upon.

I realize I'm speaking on behalf of everyone. I know that in Nova Scotia we're adopting this standard as a whole.

Hon. Pierre Dalphond: Thank you.

The Joint Chair (Mr. René Arseneault): You still have 30 seconds, Senator Dalphond.

Are you good? Okay.

Senator Osler, the floor is yours for three minutes.

Hon. Flordeliz Osler: Thank you, Mr. Chair, and thank you to the witnesses.

My question is for Dr. Gupta.

This committee has heard concerns that anyone experiencing acute emotional distress can be eligible for MAID where a mental disorder is the sole underlying medical condition. Could you please take us through how clinicians have prepared and how clinicians will assess whether a person's request for MAID is a form of suicidal ideation?

● (2025)

Dr. Mona Gupta: Thank you for that question.

Clinicians on the ground are going to be drawing upon the work that has been done by the expert panel and the task group to help clarify how to use these terms in practice.

Even without that work, I am very comfortable saying that I don't think there are any psychiatrists, physicians or nurse practitioners who think that acute distress is the equivalent of a grievous and irremediable medical condition. We all understand that an incurable condition and an advanced stage of irremediable decline requires, as it currently does under track two for other chronic conditions, a long history of failed treatment and an inability to function in a way that gives the person an adequate quality of life.

As to your question about suicidality, suicidality is already part of MAID assessment right now. When people are in crisis, MAID assessments are either not done—if that's what the person is asking for—or they are put on hold so that the crisis can be attended to. It will be exactly the same thing when a person has a mental disorder as their sole condition.

Hon. Flordeliz Osler: Thank you, Dr. Gupta.

Perhaps I'll ask the question of Dr. Gamache.

[*Translation*]

Dr. Claire Gamache: I'd say the same thing.

Are you asking the same question? Yes? Okay.

Suicidality is already part of our everyday practice in psychiatry. Even people who request MAID because of physical problems or cancer may feel suicidal at times during the process. That means their case has to be reassessed. Sometimes we have to protect them from those ideas. We try to understand why they're thinking that way. That's part of the request for assistance.

As Dr. Gupta said, nobody gets MAID while in a crisis. The process is very long. The wait time for the track two process is 90 days. There's no risk around that in a crisis situation.

The Joint Chair (Mr. René Arseneault): Thank you very much, Dr. Gamache.

[*English*]

Now we'll end this session with Senator Martin.

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

My question is for Dr. Gupta.

The president of the Canadian Society of Addiction Medicine was recently quoted with respect to MAID for those suffering from mental disorders as saying, “it's not fair to exclude people from eligibility purely because their mental disorder might either partly or in full be a substance use disorder.” This suggests that CSAM believes that people suffering solely from addictions should be able to qualify for MAID. Do you agree?

Dr. Mona Gupta: In the same logic of the expert panel, we need to focus on what the complexities are and not what diagnosis the person has. I am not part of that association, and I can't comment on any of their internal discussions, but I would say that in order for a person with a substance use disorder to actually fulfill the criteria, they would have to have an extremely severe condition with probably very severe physical comorbidity along with it.

The Joint Chair (Hon. Yonah Martin): Can you point to any safeguards that would prevent someone whose most severe condition is an addiction from being assessed for MAID?

Dr. Mona Gupta: A person can make a request and be assessed, but they're not going to be eligible unless they meet the criteria and the safeguards are respected. Most people with addiction who do not have any of the sequelae of chronic and severe substance abuse would not be eligible.

The Joint Chair (Hon. Yonah Martin): I read such statements, but there's also some evidence from European countries that allow MAID for mental illnesses that twice as many women as men get MAID for mental illness—the same ratio of women to men who attempt suicide when they're suffering from mental illness.

How do you explain that gender gap in this European example, and doesn't that concern you for Canada?

Dr. Mona Gupta: It doesn't concern me, in the sense that I don't think anybody knows what it means. We can make all sorts of hypotheses about what it might mean, but nobody really knows. What I would caution you about is drawing inferences, like the one in your question with respect to male-to-female suicide ratios, because we don't know what it means.

The Joint Chair (Hon. Yonah Martin): These are all questions just to say how concerned I am about this looming deadline and the fact that we have heard evidence, even this evening, about our lack of readiness.

On this evidence from Europe, we often talk about evidence that we can draw from and learn from for Canada. These are very concerning examples.

● (2030)

The Joint Chair (Mr. René Arseneault): Thank you, Senator Martin.

[*Translation*]

I thank all the witnesses for being here with us, for participating in the process and for answering questions. We know there's never enough time, but those are the rules.

Thank you for coming.

[*English*]

We will now suspend briefly to move in camera to discuss committee business. For our colleague Mr. Angus, who attended virtually, a Zoom link for in camera has been sent already.

We will take about five minutes.

[*Translation*]

We'll suspend the meeting.

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