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MEDICAL ASSISTANCE IN DYING AND MENTAL DISORDER AS THE SOLE UNDERLYING MEDICAL CONDITION: A COMPLEX AND CHALLENGING CONVERSATION AMONG CANADIANS

Report of the Special Joint Committee on Medical Assistance in Dying

**Hon. Yonah Martin and Marcus Powlowski
Co-Chairs**

JUNE 2026

45th PARLIAMENT, 1st SESSION

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has the honour to present its

FIRST REPORT

Pursuant to its Orders of Reference from the Senate of Thursday, February 26, 2026, and from the House of Commons of Friday, February 13, 2026, the committee has completed its study of the eligibility of persons whose sole underlying medical condition is a mental illness to receive medical assistance in dying and has agreed to report the following:

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RECOMMENDATION

As a result of their deliberations committees may make recommendations which they include in their reports for the consideration of the Senate, the House of Commons or the Government. A recommendation related to this study is listed below.

Recommendation 1

That the Government of Canada amend the *Criminal Code* to indefinitely exclude persons whose sole underlying medical condition is a mental illness from eligibility for medical assistance in dying.

MEDICAL ASSISTANCE IN DYING AND MENTAL DISORDER AS THE SOLE UNDERLYING MEDICAL CONDITION: A COMPLEX AND CHALLENGING CONVERSATION AMONG CANADIANS

INTRODUCTION

In February 2026, the Special Joint Committee on Medical Assistance in Dying (the committee) was re-established by motions in the House of Commons¹ and Senate.² Both motions provided that,

pursuant to subsection 2(1) of An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No. 2, a special joint committee of the Senate and the House of Commons be appointed to undertake a comprehensive review relating to the eligibility of persons whose sole underlying medical condition is a mental illness to receive medical assistance in dying[.]

For this study, the committee held six meetings between 24 March and 5 May 2026, heard from 44 witnesses and received 32 written briefs, in addition to other correspondence. Among the witnesses were clinicians, researchers, academics, representatives of associations and professional bodies, government officials, people with lived experience, and legal and international experts. The committee members would like to sincerely thank all those who took the time to contribute to this important study. The subject matter is inherently complex and emotionally challenging, and it raises weighty questions for Canadians. The committee members appreciate the dedication of those working to address these issues and the courage of those who have shared their testimony.

The terminology in this report – medical assistance in dying (MAID or MAiD) where the sole underlying medical condition is a “mental illness” (MI-SUMC) or a

1 House of Commons, [Journals](#), 13 February 2026.

2 Senate, [Journals](#), 26 February 2026.

“mental disorder” (MD-SUMC) – relies on the following approach described in the committee’s first report of the 44th Parliament:

While the *Criminal Code* provisions refer to “mental illness,” which is the term used in the Expert Panel’s mandate and the motion creating this committee, the Expert Panel uses “mental disorder,” noting that there is no standard definition of “mental illness” and that using it could cause confusion. In addition, the Expert Panel explains that:

A comprehensive review of the knowledge available on the topic of MAiD for mental illness required by the 2016 MAiD legislation (Council of Canadian Academies, 2018) recommended the use of the standard clinical term, ‘mental disorder.’ Therefore, throughout this report, the Panel uses ‘mental disorder’ as that is the term used in both major diagnostic classification schemes relied upon in Canadian psychiatric practice: the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization’s International Classification of Diseases (ICD).

The Committee agrees that using the standard clinical term “mental disorder” is preferable to “mental illness,” and has used that term throughout this interim report, except where directly quoting a witness or referring to the *Criminal Code* provisions.³

This terminological ambiguity remained unresolved throughout the present study. Some witnesses may have chosen either of the two terms deliberately, while others may have used them interchangeably. This report attempts to be faithful to the context in which a term arises, such as a witness’s statement or legislation, while prioritizing, to the extent possible, the approach endorsed in the committee’s previous report.⁴

BACKGROUND

In the 2015 case of *Carter v. Canada (Attorney General)* (*Carter*),⁵ the Supreme Court of Canada (Supreme Court) held that the *Criminal Code*⁶ provisions that prohibit a person from assisting another to die by suicide unjustifiably infringed section 7 of the *Canadian Charter of Rights and Freedoms* (Charter),⁷ which guarantees the right to life, liberty and

3 Parliament of Canada, Special Joint Committee on Medical Assistance in Dying (AMAD), [Medical Assistance in Dying and Mental Disorder as the Sole Underlying Condition: An Interim Report](#), First report, June 2022, p. 2.

4 Similarly, this report uses other terms like “euthanasia” or “assisted suicide” in keeping with witnesses’ statements and document sources.

5 [Carter v. Canada \(Attorney General\)](#), 2015 SCC 5.

6 [Criminal Code](#), R.S.C. 1985, c. C-46.

7 [Canadian Charter of Rights and Freedoms](#), Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982*, 1982, c. 11 (U.K.).

security of the person. It further held that those *Criminal Code* provisions were of no force or effect to the extent that they prohibited physician-assisted dying for competent adults who consent to such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering. The Supreme Court suspended its declaration of invalidity for 12 months. It later granted a four-month extension of the suspension of the declaration of invalidity, while permitting persons wishing to seek physician assistance in accordance with the *Carter* criteria to apply for judicial authorization during the suspension period.⁸

In May 2016, in the context of such an application for judicial authorization in the case of *Canada (Attorney General) v. E.F. (E.F.)*,⁹ the Court of Appeal of Alberta held that the *Carter* criteria could apply to persons with psychiatric conditions.

In June 2016, Parliament passed Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying),¹⁰ to remove criminal liability for medical and nurse practitioners who provide MAID to eligible persons whose natural death is reasonably foreseeable (now known as “Track 1”), when done in accordance with the provisions added to the *Criminal Code*. Quebec had previously passed, in 2014, its own assisted-dying law, the *Act respecting end-of-life care*,¹¹ which also restricted access to MAID to persons at the “end of life.”

In 2021, following the Superior Court of Quebec’s decision in *Truchon c. Procureur général du Canada (Truchon)*,¹² the passage of Bill C-7, An Act to amend the Criminal Code (medical assistance in dying),¹³ provided a pathway to MAID with different safeguards for those whose natural death is not reasonably foreseeable (known as “Track 2”). Bill C-7 also added a provision to the *Criminal Code* establishing that “a mental illness is not considered to be an illness, disease or disability” for the purpose of determining eligibility for MAID. This exclusionary provision was set to be repealed on 17 March 2023. On 9 March 2023, the date of the repeal was pushed to 17 March 2024,

8 [Carter v. Canada \(Attorney General\)](#), 2016 SCC 4.

9 [Canada \(Attorney General\) v E.F.](#), 2016 ABCA 155 (CanLII).

10 [Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts \(medical assistance in dying\)](#), 42nd Parliament, 1st Session (S.C. 2016, c. 3).

11 Quebec, [Act respecting end-of-life care](#), CQLR, c. S-32.0001.

12 [Truchon c. Procureur général du Canada](#), 2019 QCCS 3792 (CanLII).

13 [Bill C-7, An Act to amend the Criminal Code \(medical assistance in dying\)](#), 43rd Parliament, 2nd Session (S.C. 2021, c. 2).

through the enactment of Bill C-39, An Act to amend An Act to amend the Criminal Code (medical assistance in dying).¹⁴

In June 2023, Quebec amended its assisted-dying law to prohibit MAID for a mental disorder other than a neurocognitive disorder,¹⁵ among other changes.

In March 2026, Alberta introduced Bill 18, Safeguards for Last Resort Termination of Life Act.¹⁶ The bill seeks notably to limit MAID eligibility to persons whose natural death is reasonably foreseeable within 12 months and to prohibit MAID MI-SUMC.¹⁷ Bill 18 received Royal Assent on 14 May 2026 and is to come into force on proclamation.

Third Report of the Special Joint Committee on Medical Assistance in Dying and Bill C-62, An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No. 2

In October 2023, the committee was re-established to study the extent to which Canada was prepared for a safe and adequate application of MAID MD-SUMC. On 29 January 2024, the committee tabled its third report,¹⁸ concluding that the health system in Canada was not prepared for MAID MD-SUMC and recommending

- a. [t]hat MAID MD-SUMC should not be made available in Canada until the Minister of Health and the Minister of Justice are satisfied, based on recommendations from their respective departments and in consultation with their provincial and territorial counterparts and with Indigenous Peoples, that it can be safely and adequately provided; and
- b. [t]hat one year prior to the date on which it is anticipated that the law will permit MAID MD-SUMC, pursuant to subparagraph (a), the House of Commons and the Senate re-establish the Special Joint Committee on Medical Assistance In Dying in order to verify the degree of preparedness attained for a safe and adequate application of MAID MD-SUMC.¹⁹

14 [Bill C-39, An Act to amend An Act to amend the Criminal Code \(medical assistance in dying\)](#), 44th Parliament, 1st Session (S.C. 2023, c. 1).

15 Quebec, [Act respecting end-of-life care](#), CQLR, c. S-32.0001, ss. 26(4) and 29.1(2)(d)(ii).

16 Alberta, [Bill 18, Safeguards for Last Resort Termination of Life Act](#), 31st Legislature, 2nd Session.

17 *Ibid.*, cl. 4(2).

18 AMAD, [MAID and Mental Disorders: The Road Ahead](#), Third report, January 2024.

19 *Ibid.*, pp. 17–18.

The report was not unanimous; four out of five senators on the committee issued dissenting opinions, while members from the Conservative Party of Canada and the Bloc Québécois issued supplementary opinions.

On 29 February 2024, Bill C-62, An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No. 2,²⁰ was enacted. This legislation further extended the timeline of the exclusion by three years, to 17 March 2027. It also required that

[a] comprehensive review relating to the eligibility of persons whose sole underlying medical condition is a mental illness to receive medical assistance in dying ... be undertaken by a Joint Committee of both Houses of Parliament designated for that purpose.²¹

REVIEW RELATING TO THE ELIGIBILITY TO RECEIVE MEDICAL ASSISTANCE IN DYING OF PERSONS WHOSE SOLE UNDERLYING MEDICAL CONDITION IS A MENTAL ILLNESS

To be eligible for MAID, a person must – among other requirements – be capable of making health-related decisions, have a “grievous and irremediable medical condition” and make a voluntary request for MAID.²²

A “grievous and irremediable medical condition” means that the person has a “serious and incurable illness, disease or disability” and is in an advanced state of irreversible decline in capability. The illness, disease or disability, or that state of decline, must cause the person enduring physical or psychological suffering that is intolerable to the person and cannot be relieved under conditions that the person considers acceptable. Two independent medical or nurse practitioners must be of the opinion that all of the eligibility criteria have been met. For persons whose natural death is not reasonably foreseeable, if neither of the two practitioners has expertise in the medical condition that is causing the person’s suffering, a practitioner who has such expertise must be consulted. In all cases, a person may withdraw the request for MAID at any time and must give express consent to receive MAID.²³

20 [Bill C-62, An Act to amend An Act to amend the Criminal Code \(medical assistance in dying\), No. 2](#), 44th Parliament, 1st Session (S.C. 2024, c. 1).

21 *Ibid.*, cl. 2(1).

22 [Criminal Code](#), R.S.C. 1985, c. C-46, s. 241.2(1).

23 *Ibid.*, ss. 241.2(2)–241.2(3.1). See also Health Canada, [Medical assistance in dying: Overview](#).

For the present review relating to the eligibility to receive MAID of persons whose sole underlying medical condition is a mental illness, the committee received evidence on general preparations that have been undertaken since January 2024 and on the state of readiness as it applies to clinicians, health systems and regulations. It also heard from witnesses who spoke of lessons that may be drawn from international experiences or of their positions on MAID more broadly. The following sections summarize that evidence.

General Developments Since January 2024

Sarah Lawley, from the Department of Health, highlighted the creation of a federal–provincial/territorial committee on MAID in 2024. This committee supports inter-jurisdictional senior-level discussions and the sharing of best practices, including on preparations for the expansion.²⁴

Ms. Lawley noted that levels of readiness and approaches varied across jurisdictions, as illustrated by the legislative initiatives in Quebec and Alberta, for example. She explained that

[e]ach jurisdiction is able to design a health system to deliver MAID that aligns with what its jurisdiction is asking for. It can be more strict [than the *Criminal Code*] in its requirements for MAID, but it can't be more permissive, so every jurisdiction has a slightly different approach to the way it is delivering MAID and the way its assessment process works.²⁵

As a Department of Justice official explained, “The Criminal Code doesn't provide a right for MAID. It simply decriminalizes certain offences if certain rules are followed.”²⁶ Researcher Eliana Close noted that provincial “variability is [not] necessarily a problem, because ultimately it's up to the provinces to decide how to deliver MAID. Depending on the local context, different mechanisms of regulation can be more appropriate.”²⁷

In correspondence dated 30 April 2026 and shared with the committee, the Quebec Minister of Health and Minister Responsible for Seniors and Caregivers wrote to her federal counterpart, describing that province's current position on MAID MD-SUMC. This

24 AMAD, [Evidence](#), 14 April 2026, 1835 (Sarah Lawley, Assistant Deputy Minister, Health Policy Branch, Department of Health).

25 AMAD, [Evidence](#), 14 April 2026, 1845 (Sarah Lawley).

26 AMAD, [Evidence](#), 14 April 2026, 1855 (Kimberly Gibner, Deputy Assistant Deputy Minister, Policy Sector, Department of Justice).

27 AMAD, [Evidence](#), 27 April 2026, 2005 (Dr. Eliana Close, End of Life Research Program, Australian Centre for Health Law Research, Queensland University of Technology, as an individual).

position is reflected in its amended assisted-dying law and was informed by the 2021 report of the Select Committee on the Evolution of the Act respecting end-of-life care, which recommended that access to MAID not be extended to persons whose only medical condition is a mental disorder.²⁸ Nevertheless, the Quebec minister urged continued consideration of this issue, in the federal and Quebec legislatures, as well as among the general public.²⁹

According to Ms. Lawley, save for Quebec and Alberta, “[t]here are others that are preparing and are quite actively ready. ... [T]he vast majority of them are in the process of preparing to be ready for March [2027].”³⁰ She added that they “are building governance to bring together their MAID and mental health systems and increasing training and clinical supports for assessors.”³¹

Helen Long, representing Dying with Dignity Canada, noted that 80% of Canadians who were polled support access to MAID MI-SUMC.³² The Association for Reformed Political Action Canada, in a written brief, cited 2023 polling from Angus Reid indicating that only 28% of Canadians supported MAID for mental illness, while 50% opposed it, and that 82% said MAID should not be expanded without first improving access to mental health care.³³

Clinical Readiness

Dr. Mona Gupta explained that clinical readiness requires clinical guidance, training and a community of practice that can support mentorship, supervision and case consultation.³⁴ According to some witnesses, the relevant training, practice standards and guidelines have

28 National Assembly of Quebec, Select Committee on the Evolution of the Act respecting end-of-life care, [Report of the Select Committee on the Evolution of the Act Respecting End-of-Life Care](#), December 2021, p. 57.

29 Sonia Bélanger, Minister of Health and Minister Responsible for Seniors and Caregivers, Letter to the Federal Minister of Health (Re: Quebec’s position on the eligibility for medical assistance in dying of persons whose only medical condition is a mental disorder), 30 April 2026.

30 AMAD, [Evidence](#), 14 April 2026, 1855 (Sarah Lawley).

31 AMAD, [Evidence](#), 14 April 2026, 1835 (Sarah Lawley).

32 AMAD, [Evidence](#), 5 May 2026, 1950 (Helen Long, Chief Executive Officer, Dying with Dignity Canada). See Dying with Dignity, [MAID Tracking Survey](#), January 2026 (poll conducted by Environics Research).

33 Association for Reformed Political Action (ARPA) Canada, [Protecting Canadians with Mental Illness](#), Brief submitted to AMAD.

34 AMAD, [Evidence](#), 24 March 2026, 2010, 2020 (Dr. Mona Gupta, Full Clinical Professor, Department of Psychiatry and Addiction, Université de Montréal, as an individual).

been developed for MAID MD-SUMC, and some providers and assessors are ready for the expansion.³⁵

For others, and as summarized by Melissa Prokopy of the Ontario Hospital Association, there is still no clear agreement among clinicians on the approach to assessing eligibility – including determining irremediability and distinguishing between a reasoned MAID request and suicidal intent – or on the adequacy of guidelines, the existence of a professional consensus or the capacity of Canada’s health systems.³⁶ These points are discussed below.

Practice Standards and Clinical Guidelines

Canadian Psychiatric Association Guidance

In March 2026, the Canadian Psychiatric Association (CPA) published a document entitled *Canadian Guidance on Medical Assistance in Dying (MAID): Evaluating the “Grievous and Irremediable” Eligibility Criterion in Persons with Mental Disorders who Request MAID and Managing Suicide Risk during the Process for All MAID Eligibility Requests*.³⁷ In correspondence sent to the committee, the CPA indicated that the year-long study conducted for this guidance document involved 25 external experts. The recommendations were formulated relying on international academic literature and using the Delphi technique, “a common research method used to reach consensus about a specific issue or complex problem when there is limited evidence or contentiousness.”³⁸ The CPA further notes that the recommendations are consistent

35 AMAD, [Evidence](#), 24 March 2026, 2015, 2020 (Mona Gupta); AMAD, [Evidence](#), 24 March 2026, 2110 (Jocelyn Downie, Professor Emeritus, Faculties of Law and Medicine, Dalhousie University, as an individual); AMAD, [Evidence](#), 27 April 2026, 1850 (Dr. Stefanie Green, MAiD Provider, Canadian Association of MAiD Assessors and Providers); AMAD, [Evidence](#), 27 April 2026, 1905 (Dr. Gordon Gubitza, MAiD Provider, Canadian Association of MAiD Assessors and Providers); and AMAD, [Evidence](#), 27 April 2026, 1945 (Dr. Douglas Grant, Registrar and Chief Executive Officer, College of Physicians and Surgeons of Nova Scotia).

36 AMAD, [Evidence](#), 27 April 2026, 2130 (Melissa Prokopy, Vice-President, Policy and Advocacy, Ontario Hospital Association).

37 Canadian Psychiatric Association (CPA), [Canadian Guidance on Medical Assistance in Dying \(MAID\): Evaluating the “Grievous and Irremediable” Eligibility Criterion in Persons with Mental Disorders who Request MAID and Managing Suicide Risk during the Process for All MAID Eligibility Requests](#) [pre-print], March 2026.

38 Jitender Sareen et al., “[Canadian Psychiatry Human Resource Planning: Delphi-Method Study of Academic Chairs of Psychiatry of Canada](#),” *The Canadian Journal of Psychiatry*, Vol. 71, No. 3, March 2026. See also CPA, [Canadian Guidance on Medical Assistance in Dying \(MAID\): Evaluating the “Grievous and Irremediable” Eligibility Criterion in Persons with Mental Disorders who Request MAID and Managing Suicide Risk during the Process for All MAID Eligibility Requests](#) [pre-print], March 2026, p. 5.

with existing approaches in analogous scenarios, such as when persons with mental disorders refuse life-sustaining or life-saving treatments.³⁹

The CPA's guidance on assessing the grievous and irremediable nature of a medical condition includes recommendations such as the following:

- “[T]he Assessor should explore the reasons a Requester has not accessed standard treatments or supports for their illness, disease, or disability where this is the case.”
- “The Assessor should consider using criterion-referenced and evidence-informed tools as appropriate for the Requester’s diagnosis or clinical presentation.”
- “The Assessor should review any relevant medical records.”
- “[T]he Assessor should explore treatment attempts made up to that point, including their duration and intensity, outcomes of those treatments, and the severity and duration of illness, disease, or disability.”
- “The Assessor should adopt a life course and biopsychosocial approach when exploring the various dimensions of the Requester’s experience of suffering.”
- “If social factors are the sole or primary cause of the Requester’s suffering, the Requester would not be considered to have a grievous and irremediable medical condition.”⁴⁰

Guidance on managing a requester’s suicide risk includes recommendations such as the following:

4. The Assessor should be aware of the Requester’s previous suicide behaviour and current suicidal ideation. The Assessor should seek this information from the Requester, clinicians involved in the Requester’s care, important others (e.g., family members, caregivers), and (or) from a review of medical records.

39 CPA, Correspondence submitted to AMAD (Re: AMAD meeting of 14 April 2026), 20 April 2026, p. 2.

40 CPA, [Canadian Guidance on Medical Assistance in Dying \(MAID\): Evaluating the “Grievous and Irremediable” Eligibility Criterion in Persons with Mental Disorders who Request MAID and Managing Suicide Risk during the Process for All MAID Eligibility Requests](#) [pre-print], March 2026, pp. 8–9.

5. The Assessor must determine whether a person’s request for MAiD arises from an acutely distressing circumstance, reflects suicidal ideation as a symptom of a psychiatric condition, or is a reasoned wish to die arising from the suffering related to the Requester’s medical condition(s).

- Requesters in an acute suicidal crisis cannot be assessed for MAiD.⁴¹

In Dr. Gupta’s assessment, the CPA guidelines are based on sound methodology and supported by a review of the scientific literature. She stated that such guidelines from the CPA, together with others from the Canadian Association of MAiD Assessors and Providers (CAMAP), demonstrate that “clinicians from various disciplines agree on how to assess the relevant aspects of a request for MAiD, and they are prepared to do so.”⁴² Certain other witnesses concurred that the CPA document reflected good practice.⁴³

Some witnesses took the position that the CPA document does not constitute adequate guidance.⁴⁴ Dr. K. Sonu Gaiind was critical of the CPA’s document, stating that “it lacks evidence” and is based on “a constructed consensus that most psychiatrists do not share.”⁴⁵ According to Dr. Sanjeev Sockalingam, representing the Centre for Addiction and Mental Health, the document does not lay out evidence-based criteria but, rather, merely an assessment process.⁴⁶ Others pointed out that it had not been peer-reviewed.⁴⁷

41 Ibid., p. 11.

42 AMAD, [Evidence](#), 24 March 2026, 1945 (Mona Gupta).

43 AMAD, [Evidence](#), 14 April 2026, 2025 (Dr. Claire Gamache, Psychiatrist, Association des médecins psychiatres du Québec); AMAD, [Evidence](#), 27 April 2026, 1925 (Gordon Gubitz); and AMAD, [Evidence](#), 5 May 2026, 1925 (Dr. Sisco van Veen, Psychiatrist, as an individual).

44 AMAD, [Evidence](#), 14 April 2026, 2000 (Dr. Karin Neufeld, Psychiatrist and Chair of Department of Psychiatry, McMaster University, as an individual); AMAD, [Evidence](#), 14 April 2026, 2000 (Dr. Ramona Coelho, Family Physician, as an individual); AMAD, [Evidence](#), 14 April 2026, 2045 (Dr. Harvey Max Chochinov, Distinguished Professor of Psychiatry, University of Manitoba, as an individual); AMAD, [Evidence](#), 21 April 2026, 1905 (Dr. John Maher, Psychiatrist, Ontario Association for ACT & FACT); AMAD, [Evidence](#), 27 April 2026, 1940, 1955 (Dr. Allison Crawford, Chief Medical Officer, 9-8-8: Suicide Crisis Helpline); and AMAD, [Evidence](#), 28 April 2026, 1840 (Dr. Sanjeev Sockalingam, Senior Vice-President, Education and Chief Medical Officer, Centre for Addiction and Mental Health).

45 AMAD, [Evidence](#), 24 March 2026, 2030 (Dr. K. Sonu Gaiind, Professor of Psychiatry, Faculty of Medicine, University of Toronto, as an individual). See also AMAD, [Evidence](#), 14 April 2026, 1945 (Ramona Coelho); AMAD, [Evidence](#), 14 April 2026, 2120 (Dr. Pierre Gagnon, Psychiatrist, as an individual); and AMAD, [Evidence](#), 27 April 2026, 2135 (Dr. Jitender Sareen, Head of Psychiatry and Professor, Department of Psychiatry, University of Manitoba, as an individual).

46 AMAD, [Evidence](#), 28 April 2026, 1840 (Sanjeev Sockalingam).

47 AMAD, [Evidence](#), 14 April 2026, 1955 (Karin Neufeld); and AMAD, [Evidence](#), 27 April 2026, 2135 (Jitender Sareen).

Dr. Karin Neufeld stated that it did not reflect a consensus among the chairs of psychiatry.⁴⁸

Assessing Irremediability

Witnesses were divided on the question of whether it is possible to assess the irremediability of mental disorders. Dr. Gupta indicated that CAMAP has, since 2024, published a number of guidance documents, particularly on assessing incurability. She added that the CPA guidelines offer a strategy for determining whether a mental disorder constitutes a serious and irreversible medical condition.⁴⁹ Some witnesses, while acknowledging the complexity of the matter, asserted that clinicians are equipped to assess irremediability.⁵⁰

Nevertheless, other witnesses testified that it would not be possible – either at this moment or at any future time – to reliably determine irremediability in mental illness⁵¹ or “reliably distinguish in practice those rare cases where suffering is truly irremediable from those where despair may yet be treatable.”⁵²

For example, Dr. Sockalingam stated that “[t]here are currently no established criteria or consensus among psychiatrists about whether or when a mental illness should be considered irremediable.” He added that Canada needs to “invest significantly in

48 AMAD, [Evidence](#), 14 April 2026, 1955 (Karin Neufeld).

49 AMAD, [Evidence](#), 24 March 2026, 2015, 2030 (Mona Gupta). See also Canadian Association of MAiD Assessors and Providers, [Assessing Incurability For Requests For Medical Assistance In Dying](#), May 2025.

50 AMAD, [Evidence](#), 27 April 2026 (Gordon Gubitz); AMAD, [Evidence](#), 14 April 2026, 1940 (Claire Gamache); AMAD, [Evidence](#), 14 April 2026, 2005 (Dr. Guillaume Barbès-Morin, Psychiatrist, Association des médecins psychiatres du Québec); and AMAD, [Evidence](#), 5 May 2026, 1845 (Sisco van Veen).

51 AMAD, [Evidence](#), 24 March 2026, 2020 (K. Sonu Gaiind); AMAD, [Evidence](#), 14 April 2026, 1945, 2000 (Ramona Coelho); AMAD, [Evidence](#), 14 April 2026, 2000 (Karin Neufeld); AMAD, [Evidence](#), 14 April 2026, 2115 (Harvey Max Chochinov); AMAD, [Evidence](#), 14 April 2026, 2050 (Pierre Gagnon); AMAD, [Evidence](#), 21 April 2026, 1840 (John Maher); AMAD, [Evidence](#), 27 April 2026, 2115 (Jitender Sareen); AMAD, [Evidence](#), 27 April 2026, 2120 (Dr. Sandip Singh Gandham, Assistant Clinical Professor, Department of Family Medicine, University of Alberta, as an individual); AMAD, [Evidence](#), 28 April 2026, 1830 (Prof. Brian Mishara, Director, Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices, Université du Québec à Montréal, as an individual); AMAD, [Evidence](#), 28 April 2026, 1940 (Neil Belanger, Chief Executive Officer, Indigenous Disability Canada); and AMAD, [Evidence](#), 5 May 2026, 1835 (Dr. Jim van Os, Professor of Psychiatry, as an individual).

52 AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham).

research” and that “[i]t will take a significant amount of time” to obtain solid evidence on diagnostic and clinical assessment tools in mental health.⁵³

Dr. Neufeld recounted her work with a MAID requester who would have met the eligibility criteria, in her view, and the subsequent improvements to his health and life, which now includes a will to live.⁵⁴ The committee heard from other witnesses who shared stories of individuals with longstanding mental health issues that had improved.⁵⁵ Dr. John Maher asserted that suicidal thinking and “[s]uffering can always be reduced.”⁵⁶

Furthermore, according to Dr. Harvey Max Chochinov, the availability of MAID may undermine the therapeutic relationship. The strength of that relationship is, in his opinion, the most helpful factor for predicting successful outcomes.⁵⁷ Some witnesses warned that, in the absence of established criteria or consensus, assessments may be “inherently subjective and arbitrary,”⁵⁸ biased or discriminatory.⁵⁹

Dr. Lilian Thorpe stated that MAID MD-SUMC “should be occasionally available in rare circumstances,” although she highlighted the unpredictable nature of mental disorders.⁶⁰

Another point of divergence among witnesses was their understanding of the number of treatments that patients must have undergone before they can be determined to have an irremediable condition.⁶¹ Dr. Gupta reminded the committee that, even though

53 AMAD, [Evidence](#), 28 April 2026, 1840, 1845 (Sanjeev Sockalingam).

54 AMAD, [Evidence](#), 14 April 2026, 1950 (Karin Neufeld).

55 See AMAD, [Evidence](#), 14 April 2026, 2045 (Harvey Max Chochinov); and AMAD, [Evidence](#), 27 April 2026, 1835 (Dr. Margaret McKinnon, Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, as an individual). See also AMAD, [Evidence](#), 28 April 2026, 1900 (Brian Mishara).

56 AMAD, [Evidence](#), 21 April 2026, 1840, 1920 (John Maher).

57 AMAD, [Evidence](#), 14 April 2026, 2115 (Harvey Max Chochinov). See also AMAD, [Evidence](#), 28 April 2026, 1905 (Brian Mishara).

58 AMAD, [Evidence](#), 28 April 2026, 1840 (Sanjeev Sockalingam).

59 AMAD, [Evidence](#), 14 April 2026, 1945 (Ramona Coelho). See also Ramona Coelho, “[Discrimination-driven deaths – Analysing Ontario Coroner Reports on Euthanasia and Assisted Suicide](#),” *BMJ Supportive & Palliative Care*, 4 December 2024.

60 AMAD, [Evidence](#), 27 April 2026, 1840, 1900 (Dr. Lilian Thorpe, Full Professor, Department of Community Health and Epidemiology and Department of Psychiatry, University of Saskatchewan, as an individual).

61 See, for example, AMAD, [Evidence](#), 24 March 2026, 1950 (Mona Gupta); AMAD, [Evidence](#), 14 April 2026, 2030 (Karin Neufeld); AMAD, [Evidence](#), 14 April 2026, 2030 (Ramona Coelho); AMAD, [Evidence](#), 14 April 2026, 2025 (Claire Gamache); AMAD, [Evidence](#), 21 April 2026, 1840 (John Maher); and AMAD, [Evidence](#), 27 April 2026, 2155 (Jitender Sareen).

capable persons may refuse a recommended treatment, such a refusal does not render them automatically eligible – in other words, the “process is an eligibility assessment. It is not intended to provide unconditional access to MAID.”⁶²

Distinguishing Requests for Medical Assistance in Dying from Suicidality

Witnesses diverged on the question of whether reasoned MAID requests can be differentiated from suicidality. For some witnesses, making this distinction may be complex but is not impossible.⁶³ Dr. Sisco van Veen referred to the use by Dutch psychiatrists of the “well known and internationally recognized” Appelbaum and Grisso criteria for assessing patients’ capacities to consent to or refuse treatment.⁶⁴

Dr. Gupta noted that the CPA guidance addresses suicide risk in the context of MAID requests and that MAID assessments must not occur during periods of crisis. She added that suicide-risk evaluation is relevant to all MAID assessments, that suicidality can attach to physical as well as mental disorders, and that the mere existence of a mental disorder does not necessarily make a person at risk for suicide. She questioned “why it is acceptable to allow MAID if a person with both a mental disorder and a physical disorder has experienced suicidality, yet this is a justification to exclude those with mental disorders as their sole condition.”⁶⁵

Dr. Gordon Gubitz, from CAMAP, and Dr. Claire Gamache, from the Association des médecins psychiatres du Québec, also told the committee that suicide-risk evaluations are routinely part of their clinical work.⁶⁶ Dr. Douglas Grant explained that “[i]t’s a regular feature of medicine ... to identify whether a patient has decisional capacity and can provide informed consent,” including in complex cases.⁶⁷

However, others testified that the delineation between MAID requests and suicidality was not framed by clear guidance, was inherently difficult or was altogether

62 AMAD, [Evidence](#), 24 March 2026, 1950, 2000 (Mona Gupta).

63 AMAD, [Evidence](#), 24 March 2026, 1955 (Mona Gupta); AMAD, [Evidence](#), 14 April 2026, 2025 (Claire Gamache); AMAD, [Evidence](#), 27 April 2026, 1850 (Stefanie Green); and AMAD, [Evidence](#), 5 May 2026, 1920 (Sisco van Veen).

64 AMAD, [Evidence](#), 5 May 2026, 1920 (Sisco van Veen).

65 AMAD, [Evidence](#), 24 March 2026, 1945, 1955 (Mona Gupta).

66 AMAD, [Evidence](#), 14 April 2026, 1940, 2025 (Claire Gamache); AMAD, [Evidence](#), 27 April 2026, 1910 (Gordon Gubitz).

67 AMAD, [Evidence](#), 27 April 2026, 2000 (Douglas Grant).

impossible.⁶⁸ Dr. Sandip Singh Gandham expressed the “worry that in some cases, we may not be responding to an autonomous, enduring request for assisted dying, but rather to the voice of the illness itself.”⁶⁹

According to Dr. Gaind, MAID reporting data “ignores many known suicide risk factors, so we can’t know the full scope of how much suicidality fuels MAID requests.” However, he indicated that the evidence shows “strong suicide risk factors” associated with Track 2 requests (that is, involving people whose natural death was not reasonably foreseeable). In his opinion, people with mental illness have higher rates of psychosocial suffering, and “these factors related to life suffering are actually the same as suicide risk factors,” such that distinguishing between the two becomes impossible.⁷⁰ Professor Brian Mishara pointed to research showing that, in Canada, over 90% of people who die by suicide have been or could have been diagnosed with mental illness.⁷¹

Dr. Pierre Gagnon warned that compassion fatigue among caregivers, patients and families can also complicate decision-making.⁷² He nevertheless indicated that he has previously assessed patients with mental disorders as being capable of deciding to refuse or discontinue life-sustaining or life-saving treatments.⁷³

Some psychiatrists highlighted what they saw as an inherent incoherence if “[p]sychiatry claims it can both prevent suicide in one patient and help finalize suicide in another with the same suffering.”⁷⁴ As Dr. Jitender Sareen explained, “[t]his goes to the core psychiatric practice, which is grounded in assessing and treating hopelessness and preventing suicide.”⁷⁵

68 AMAD, [Evidence](#), 14 April 2026, 2000 (Karin Neufeld); AMAD, [Evidence](#), 14 April 2026, 2050, 2105 (Pierre Gagnon); AMAD, [Evidence](#), 14 April 2026, 2115 (Harvey Max Chochinov); AMAD, [Evidence](#), 21 April 2026, 1840 (John Maher); AMAD, [Evidence](#), 27 April 2026, 1940 (Allison Crawford); AMAD, [Evidence](#), 27 April 2026, 2115 (Jitender Sareen); AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham); AMAD, [Evidence](#), 28 April 2026, 1830 (Brian Mishara); AMAD, [Evidence](#), 28 April 2026, 1840 (Sanjeev Sockalingam); and AMAD, [Evidence](#), 5 May 2026, 1900 (Jim van Os).

69 AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham).

70 AMAD, [Evidence](#), 24 March 2026, 1940 (K. Sonu Gaind).

71 AMAD, [Evidence](#), 28 April 2026, 1925 (Brian Mishara).

72 AMAD, [Evidence](#), 14 April 2026, 2050 (Pierre Gagnon). See also AMAD, [Evidence](#), 14 April 2026, 2130 (Harvey Max Chochinov).

73 AMAD, [Evidence](#), 14 April 2026, 2140 (Pierre Gagnon). See also AMAD, [Evidence](#), 21 April 2026, 2135 (Daphne Gilbert, Full Professor, University of Ottawa, Faculty of Law, as an individual).

74 AMAD, [Evidence](#), 5 May 2026, 1835 (Jim van Os).

75 AMAD, [Evidence](#), 27 April 2026, 2115 (Jitender Sareen).

Differentiating Mental and Physical Conditions

Several witnesses emphasized that the suffering associated with mental disorders is real and can be unbearable.⁷⁶ Some told the committee that complex cases exist for both physical and mental conditions alike, that there was no justification for distinguishing between the two, and that no new complexities would arise if the expansion were to proceed.⁷⁷ Although Dr. van Veen saw differences between chronic physical and psychiatric suffering, he did not think that these differences were sufficient to justify a complete ban of psychiatric MAID. He further noted that suffering is always subjective.⁷⁸

For other witnesses like Dr. Gagnon, a distinction was justified on the grounds that “[s]uicidal thoughts are inherently part of mental illness, and that is not the case with physical illness.”⁷⁹

Gabrielle Peters, representing Disability Filibuster, stated that “[t]he division between physical and mental illness is asserted and maintained by the medical model and the Canadian state.” She added that “[c]o-occurrence of chronic illness and mental illness is common.”⁸⁰

Dr. Guillaume Barbès-Morin testified that most psychiatrists in Canada are equipped to assess all the criteria, and he expressed concern at the possibility that patients with mental illness may experience discrimination “just because ... we can’t see the illness on a scanner.” He indicated that mental illness is no different from disorders involving the brain, such as multiple sclerosis, and that clinicians are able to recognize when a patient is doing well or suffering terribly.⁸¹ In Dr. Gamache’s words: “The psychiatrists in Quebec

76 AMAD, [Evidence](#), 24 March 2026, 1945 (Mona Gupta); AMAD, [Evidence](#), 14 April 2026, 2005 (Guillaume Barbès-Morin); AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham); AMAD, [Evidence](#), 28 April 2026, 1840 (Sanjeev Sockalingam); AMAD, [Evidence](#), 5 May 2026, 1845 (Sisco van Veen); and AMAD, [Evidence](#), 5 May 2026, 1900 (Jim van Os). See also AMAD, [Evidence](#), 28 April 2026, 1925 (Brian Mishara)

77 AMAD, [Evidence](#), 24 March 2026, 2135 (Jocelyn Downie); AMAD, [Evidence](#), 14 April 2026, 1940, 2000, 2025 (Claire Gamache); AMAD, [Evidence](#), 24 March 2026, 1945, 2005 (Mona Gupta); AMAD, [Evidence](#), 14 April 2026, 2005, 2035 (Guillaume Barbès-Morin); AMAD, [Evidence](#), 27 April 2026, 1910 (Gordon Gubitz); AMAD, [Evidence](#), 5 May 2026, 1845 (Sisco van Veen); and AMAD, [Evidence](#), 5 May 2026, 1950 (Helen Long). See also AMAD, [Evidence](#), 14 April 2026, 2125 (Pierre Gagnon).

78 AMAD, [Evidence](#), 5 May 2026, 1845, 1935 (Sisco van Veen). See also AMAD, [Evidence](#), 28 April 2026, 1840 (Sanjeev Sockalingam).

79 AMAD, [Evidence](#), 14 April 2026, 2130 (Pierre Gagnon). See also AMAD, [Evidence](#), 27 April 2026, 2115 (Jitender Sareen); and AMAD, [Evidence](#), 28 April 2026, 1925 (Brian Mishara).

80 AMAD, [Evidence](#), 21 April 2026, 1950 (Gabrielle Peters, Co-Founder, Disability Filibuster).

81 AMAD, [Evidence](#), 14 April 2026, 2005 (Guillaume Barbès-Morin).

consider the suffering [severe mental disorders] cause to be the equivalent of the suffering caused by physical disorders. The only real difference is the way in which they are manifested.”⁸²

Dr. Sockalingam explained that, for some physical conditions, clinicians can confirm a diagnosis and prognosis by relying on diagnostic markers and laboratory tests, whereas these options do not yet exist for mental illness, which “is defined more by differences in equities, in terms of access to treatments.”⁸³ He stressed the need for more funding and resources to advance research on mental health assessments and treatment.⁸⁴

Training and Professional Development

Dr. Stefanie Green stated that CAMAP’s MAiD curriculum is a national program, fully accredited by the Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada and Canadian Nurses Association. She also indicated that CAMAP has provided guidance on capacity, incurability and complex chronic conditions.⁸⁵ She attested to the clinical readiness of practitioners and noted that, for the past 10 years, they have been assessing patients with comorbid mental illness.⁸⁶

Dr. Green and Dr. Gubitz described various aspects of the 27-hour curriculum, which includes material on ableism and vulnerability, and indicated that over 95% of program attendees had felt it was beneficial.⁸⁷

Ms. Lawley reported the following levels of participation in the curriculum:

Participation has tripled over the past two years. We have seen a definite increase in those who identify as having a specialty in psychiatry and as general practitioners, with a tripling in the number of clinicians accessing that training, both those who identify with

82 AMAD, [Evidence](#), 14 April 2026, 1940 (Claire Gamache). See also AMAD, [Evidence](#), 14 April 2026, 2005 (Guillaume Barbès-Morin).

83 AMAD, [Evidence](#), 28 April 2026, 1850 (Sanjeev Sockalingam).

84 See also AMAD, [Evidence](#), 28 April 2026, 1850 (Sanjeev Sockalingam).

85 See Canadian Association of MAiD Assessors and Providers (CAMAP), [Assessment for Capacity to give Informed Consent for Medical Assistance in Dying \(MAiD\): Review and Recommendations](#), April 2020; CAMAP, [Assessing Incurability For Requests For Medical Assistance In Dying](#), May 2025; and CAMAP, [Medical Assistance in Dying \(MAiD\) Assessments for People with Complex Chronic Conditions](#), February 2023.

86 AMAD, [Evidence](#), 27 April 2026, 1850 (Stefanie Green).

87 AMAD, [Evidence](#), 27 April 2026, 1915 (Gordon Gubitz); and AMAD, [Evidence](#), 27 April 2026, 1930 (Stefanie Green).

a speciality in psychiatry and those who have completed the MAID module on mental health and MAID.⁸⁸

However, Professor Catherine Frazee criticized the curriculum as being “designed to make practitioners look away”⁸⁹ and avoid meaningful scrutiny. She made the following statement:

They are unable or unwilling to disentangle those structural forces—I believe you’re referring to them as social determinants of health. They’re unable to disentangle that kind of suffering in cases involving stable physical disability.

I therefore conclude that there is no basis on which to be confident that they will do so when mental illness is the sole underlying condition.⁹⁰

Position of the Profession

According to Dr. Gaind, “Most psychiatrists in the country are against expanding MAID solely for mental illness.”⁹¹ Some witnesses also underscored the 2025 position paper of the American Psychiatric Association, opposing legislation that permits MAID MI-SUMC.⁹²

Dr. Gamache stated that the Association des médecins psychiatres du Québec, which represents 25% of the psychiatrists in Canada, “believes that patients with mental disorders cannot be considered as different” and that “[p]sychiatrists are ready to support patients through that [MAID] process.”⁹³

Dr. Sareen testified that Manitoba’s psychiatry leadership council had “reached a clear consensus ... that expansion to mental disorders should not proceed.” He referred to a letter submitted to the committee by current and former chairs of psychiatry

88 AMAD, [Evidence](#), 14 April 2026, 1905 (Sarah Lawley).

89 AMAD, [Evidence](#), 21 April 2026, 1955 (Dr. Catherine Frazee, Professor Emerita, School of Disability Studies, Toronto Metropolitan University, as an individual).

90 AMAD, [Evidence](#), 21 April 2026, 2040 (Catherine Frazee). See also Catherine Frazee, “[ABLEISM ENTRENCHED: Inside the Pedagogical Politics of Canada’s MAiD Curriculum](#),” *Canadian Journal of Disability Studies*, Vol. 15, No. 1, 2026.

91 AMAD, [Evidence](#), 24 March 2026, 2030 (K. Sonu Gaind). See also AMAD, [Evidence](#), 21 April 2026, 1845 (John Maher).

92 AMAD, [Evidence](#), 27 April 2026, 2115 (Jitender Sareen). See American Psychiatric Association, [Position Statement on Psychiatric Participation in Physician Assistance in Dying](#), July 2025.

93 AMAD, [Evidence](#), 14 April 2026, 1940 (Claire Gamache).

departments across several Canadian provinces, recommending an indefinite pause to the expansion.⁹⁴

Dr. Gubitz pointed out that clinical medicine always involves differing opinions and that the requirement of two assessments for each MAID requester is to ensure “consensus of opinion around the individual case itself.”⁹⁵

Professor Jocelyn Downie differentiated clinicians’ positions on clinical readiness from the question of whether the expansion should proceed – the latter, in her view, being a decision for Parliament: “That’s a public policy decision, not a clinical decision. Clinical readiness is clinical, and the clinical community for MAID has demonstrated its readiness.”⁹⁶

Health Systems Readiness

Evidence on the readiness of Canada’s health systems focused on the capacity to ensure necessary mental health services and to support suicide prevention measures.

Mental Health System Capacity

A recurring theme across the testimony was the pressing need for increased and more equitable access to adequate mental health services.⁹⁷ Certain witnesses doubted that a person’s illness could be determined to be irremediable in the absence of sufficient

94 AMAD, [Evidence](#), 27 April 2026, 2115 (Jitender Sareen). See Jitender Sareen et al., [Preparedness for MAID for Mental Disorders as a Sole Underlying Medical Condition](#), Brief submitted to AMAD, 20 April 2026.

95 AMAD, [Evidence](#), 27 April 2026, 1925 (Gordon Gubitz).

96 AMAD, [Evidence](#), 24 March 2026, 2100 (Jocelyn Downie).

97 AMAD, [Evidence](#), 14 April 2026, 2010 (Karin Neufeld); AMAD, [Evidence](#), 14 April 2026, 2010 (Ramona Coelho); AMAD, [Evidence](#), 14 April 2026, 2010 (Guillaume Barbès-Morin); AMAD, [Evidence](#), 14 April 2026, 2115 (Harvey Max Chochinov); AMAD, [Evidence](#), 21 April 2026, 2015 (Krista Carr, Chief Executive Officer, Inclusion Canada); AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham); AMAD, [Evidence](#), 27 April 2026, 1835, 1900, 1920 (Margaret McKinnon); AMAD, [Evidence](#), 27 April 2026, 2145 (Jitender Sareen); AMAD, [Evidence](#), 27 April 2026, 1940 (Allison Crawford); AMAD, [Evidence](#), 27 April 2026, 2125 (Melissa Prokopy); AMAD, [Evidence](#), 5 May 2026, 1945 (Alician Duncan, as an individual); and AMAD, [Evidence](#), 5 May 2026, 2035 (Helen Long).

access to mental health and social services.⁹⁸ Some opined that “[w]e have an obligation to provide access to mental health treatment before providing access to MAID.”⁹⁹

Ms. Lawley underscored that mental health system capacity encompasses “access to psychiatrists for consultation and broader access to mental health services and treatments.”¹⁰⁰ She added:

A number of things have to be met before mental illness as a sole underlying condition can be a reason for medical assistance in dying. The concern around the country is whether we have the system in place that would allow supports for an individual for the duration of their illness, and I would say we do not.¹⁰¹

The following are among the statements that certain witnesses made highlighting the inadequacy of mental health care in Canada:

[Statistics from the Canadian Institute for Health Information] show us that we aren’t increasing the number of psychiatrists in our country... and it’s still below the number of family health practitioners we are providing.¹⁰²

Demand for care continues to grow, while service capacity does not. One in three Canadians reports that their needs for mental health care are unmet or only partially met. In Ontario alone, over the last four years, mental health service volumes have increased by 66%.¹⁰³

Several Canadian provinces face worse problems with access to timely and quality mental health care, as 10% of people wait for six months or more for mental health care and 50% wait for a month.¹⁰⁴

In 2025, the Canadian Institute for Health Information found that 41% of adults with a mental illness said that their needs were met not at all or only partially, while 52% of young adults reported being able to obtain not any or only limited help for their mental

98 AMAD, [Evidence](#), 27 April 2026, 2150 (Melissa Prokopy); AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham).

99 AMAD, [Evidence](#), 28 April 2026, 1830 (Brian Mishara).

100 AMAD, [Evidence](#), 14 April 2026, 1835 (Sarah Lawley).

101 AMAD, [Evidence](#), 14 April 2026, 1915 (Sarah Lawley).

102 AMAD, [Evidence](#), 14 April 2026, 1835 (Sarah Lawley).

103 AMAD, [Evidence](#), 28 April 2026, 1840 (Sanjeev Sockalingam).

104 AMAD, [Evidence](#), 24 March 2026, 2045 (Dr. Trudo Lemmens, Professor and Scholl Chair in Health Law and Policy, Jackman Faculty of Law, University of Toronto, as an individual).

illness. One out of three Canadians said they did not have access to mental health services because they were unable to pay the cost.¹⁰⁵

Ms. Lawley noted that the level of demand for psychiatrists, should the exclusion be lifted, is not yet known.¹⁰⁶ Some witnesses asserted that the expansion would result in few additional MAID approvals in practice.¹⁰⁷ For example, Dr. Gamache testified that, in her opinion, “a tiny percentage” of the 3% of the population who have severe mental disorders may become eligible.¹⁰⁸ Professor Daphne Gilbert told the committee: “[O]ne justification for continued exclusion is a speculative claim that large numbers of people will become eligible if the ban is lifted. There’s no evidence to support that claim.”¹⁰⁹

Krista Carr, representing Inclusion Canada, considered that the expansion would be “hugely wide,” given that “now we’re looking at expanding [Track 2 MAID] to 297 more labels under the definition of mental disorder in the DSM-5”¹¹⁰ (*Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition).

According to Ms. Lawley, in 2024, 4.4% of MAID provisions were for people whose natural death was not reasonably foreseeable – or 732 people. Of those 732 people, 13 were reported as having a mental illness in addition to their underlying medical condition. However, she noted that, “as practitioners are not required to provide detailed information on all of an individual’s conditions and comorbidities, this finding should be interpreted cautiously.”¹¹¹

Witnesses such as Dr. Coelho and Dr. Allison Crawford further pointed out that long wait times and inequitable access to care “can produce or exacerbate the suffering that may drive MAID requests and suicidal thoughts and behaviours.”¹¹²

105 AMAD, [Evidence](#), 28 April 2026, 1830 (Brian Mishara). See also Canadian Institute for Health Information, [Many Canadians with mental health disorders are not having their needs met](#), 23 October 2025.

106 AMAD, [Evidence](#), 14 April 2026, 1915 (Sarah Lawley).

107 AMAD, [Evidence](#), 14 April 2026, 1835 (Sarah Lawley).

108 AMAD, [Evidence](#), 14 April 2026, 1940, 2000 (Claire Gamache). See also AMAD, [Evidence](#), 14 April 2026, 2015 (Guillaume Barbès-Morin).

109 AMAD, [Evidence](#), 21 April 2026, 2100 (Daphne Gilbert).

110 AMAD, [Evidence](#), 21 April 2026, 2040 (Krista Carr).

111 AMAD, [Evidence](#), 14 April 2026, 1835 (Sarah Lawley).

112 AMAD, [Evidence](#), 27 April 2026, 1940 (Allison Crawford). See also AMAD, [Evidence](#), 14 April 2026, 1945 (Ramona Coelho).

Dr. Kevin Young, representing the Ontario Hospital Association, indicated that existing barriers to care can also complicate MAID assessments and provision. For example, in the application process, practitioners may need to facilitate consultations or seek expedited treatment for applicants, and this accelerated pathway to mental health care can further exacerbate inequities in access.¹¹³ Dr. Sockalingam noted the ethical and financial considerations that arise in decisions to prioritize MAID resources or access to effective treatments.¹¹⁴

Dr. Gagnon also highlighted the discrepancy between mental and physical medicine as regards available resources: “If we work in both physical palliative care and in psychiatry, we can see that psychiatry is the poor cousin in terms of the variety of approaches.”¹¹⁵

Professor Margaret McKinnon, speaking as a person with lived experience, asserted that Canada is not prepared for the expansion, mainly because of “inequities in the allocation of mental health resources and mental health treatments.”¹¹⁶

Suicide Risk and Prevention

Some witnesses warned that expanding MAID may lead to the “so-called suicide contagion effect,”¹¹⁷ or “Werther effect,”¹¹⁸ and undermine suicide prevention efforts.¹¹⁹ Dr. Maher noted that, in jurisdictions that have MAID, suicide rates rose faster after legalization.¹²⁰ Reference was also made to the 2025 statement of the International Association for Suicide Prevention, which takes a stance against euthanasia and assisted suicide.¹²¹

113 AMAD, [Evidence](#), 27 April 2026, 2125 (Dr. Kevin Young, Vice-President, Medical Affairs and Chief of Staff, Waypoint Centre for Mental Health, Ontario Hospital Association). See also AMAD, [Evidence](#), 28 April 2026, 1855 (Sanjeev Sockalingam).

114 AMAD, [Evidence](#), 28 April 2026, 1855 (Sanjeev Sockalingam).

115 AMAD, [Evidence](#), 14 April 2026, 2115 (Pierre Gagnon).

116 AMAD, [Evidence](#), 27 April 2026, 1900 (Margaret McKinnon).

117 AMAD, [Evidence](#), 5 May 2026, 1835, 1940 (Jim van Os). See also AMAD, [Evidence](#), 14 April 2026, 1945 (Ramona Coelho); and AMAD, [Evidence](#), 28 April 2026, 2015 (Neil Belanger).

118 AMAD, [Evidence](#), 21 April 2026, 1845 (John Maher); and AMAD, [Evidence](#), 28 April 2026, 1900 (Brian Mishara).

119 AMAD, [Evidence](#), 27 April 2026, 1940 (Allison Crawford); and AMAD, [Evidence](#), 28 April 2026, 1830 (Brian Mishara).

120 AMAD, [Evidence](#), 21 April 2026, 1840 (John Maher).

121 AMAD, [Evidence](#), 14 April 2026, 1950 (Ramona Coelho); AMAD, [Evidence](#), 27 April 2026, 1940 (Allison Crawford); and AMAD, [Evidence](#), 27 April 2026, 2115 (Jitender Sareen). See International Association for Suicide Prevention, [IASP Position Statement on Assisted Suicide and Euthanasia \(2025\)](#).

Dr. Crawford, as Chief Medical Officer of 9-8-8: Suicide Crisis Helpline, spoke of an “overlap”¹²² between persons experiencing suicidality and those considering MAID. She reported that 7% of interactions with the helpline – representing almost 70,000 calls and texts – mention MAID. She also testified that, among contacts who referenced MAID, 74% had endorsed thoughts of suicide in the previous two days, compared with 48% among other contacts.¹²³

Some witnesses suggested that the availability of MAID may help to prevent suicides.¹²⁴ Dr. Barbès-Morin expressed a concern that, in the absence of MAID as an option, “[p]atients will take their own lives because they are not being heard,” whereas “[i]f they had ongoing support, they could regain hope and they could be supported further through treatment.”¹²⁵ Dr. Thorpe similarly described a paradoxical effect, where Track-2 MAID requests lead patients “to be hooked up with resources” and to “become engaged with appropriate treatments,” such that they see an improvement in their quality of life.¹²⁶

Dr. Maher countered: “The argument that somehow a messy death justifies supporting [medically assisted] suicide misses the point completely. What it justifies is treatment to prevent getting to a messy death or MAID in the first place.”¹²⁷ Dr. van Veen explained that the relationship between suicidality and psychiatric MAID is very complex. He added that patients, especially ones with persistent suicidality, mostly “want to have a connection to talk about their death wish,” rather than wanting physicians to act on a MAID request immediately.¹²⁸

Regulatory Readiness

Finally, the committee heard about readiness from a regulatory standpoint. Some witnesses pointed to the many layers of existing oversight,¹²⁹ with Eliana Close explaining that MAID regulation involves not only the *Criminal Code* but also guidelines,

122 AMAD, [Evidence](#), 27 April 2026, 1950 (Allison Crawford).

123 AMAD, [Evidence](#), 27 April 2026, 1940, 1950 (Allison Crawford).

124 AMAD, [Evidence](#), 24 March 2026, 2120 (Jocelyn Downie).

125 AMAD, [Evidence](#), 14 April 2026, 2010 (Guillaume Barbès-Morin).

126 AMAD, [Evidence](#), 27 April 2026, 1840 (Lilian Thorpe).

127 AMAD, [Evidence](#), 21 April 2026, 1930 (John Maher).

128 AMAD, [Evidence](#), 5 May 2026, 1915 (Sisco van Veen).

129 AMAD, [Evidence](#), 27 April 2026, 1920 (Stefanie Green); AMAD, [Evidence](#), 27 April 2026, 1935 (Eliana Close); and AMAD, [Evidence](#), 27 April 2026, 1955 (Douglas Grant).

training, institutional practices and communities of practice.¹³⁰ Certain witnesses expressed concerns, notably around possible non-compliance and the perceived lack of safeguards needed to achieve the right balance between ensuring access or autonomy and protecting potentially vulnerable populations. Constitutional considerations were also raised. These discussions are summarized below.

Monitoring and Oversight

General Framework

Ms. Close stated that the federal monitoring system, which collects aggregate data on MAID provision, is “rigorous” and that “MAID is one of the most comprehensively reported medical practices in the country.” She added that “Health Canada’s annual reports on MAID are among the most detailed in the world.”¹³¹

“Oversight” in the provincial context refers to the review of individual cases for compliance with the law and applicable standards. Ms. Close and Dr. Green indicated that over 90% of MAID cases have some form of retrospective oversight through provincial mechanisms of accountability and scrutiny.¹³² Dr. Gubitz explained that certain provincial oversight systems employ retrospective chart reviews, while others use both prospective and retrospective reviews.¹³³

Ms. Close also spoke of the importance of “coal face regulation” in medicine, explaining that “[c]oal face regulation extends formal regulation into day-to-day practice and includes clinical practice recommendations, peer consultation and best practices.” As an example, she pointed to Nova Scotia’s province-wide team that is informed of all MAID cases and provides prospective support and retrospective review.¹³⁴

130 AMAD, [Evidence](#), 27 April 2026, 1935 (Eliana Close).

131 Ibid. See Health Canada, [Sixth Annual Report on Medical Assistance in Dying in Canada](#), November 2025; and [Regulations for the Monitoring of Medical Assistance in Dying](#), SOR/2018-166.

132 AMAD, [Evidence](#), 27 April 2026, 1935 (Eliana Close); and AMAD, [Evidence](#), 27 April 2026, 1920 (Stefanie Green).

133 AMAD, [Evidence](#), 27 April 2026, 1920 (Gordon Gubitz).

134 AMAD, [Evidence](#), 27 April 2026, 1935 (Eliana Close).

Regulators

The committee heard diverging views on the effectiveness of oversight provided by professional regulators.

According to Professor Downie, professional regulatory colleges are ready for the expansion of MAID.¹³⁵ Dr. Douglas Grant testified that the College of Physicians and Surgeons of Nova Scotia “will be ready because it’s our legal duty to be ready.” He also pointed to a letter from the Federation of Medical Regulatory Authorities of Canada attesting to readiness.¹³⁶

Several witnesses further noted that physicians have a professional and regulatory obligation to be competent when undertaking any clinical activity and to practise within their scope of practice.¹³⁷

Dr. Grant referred to multiple layers of regulation and professional standards, including the duty to report unprofessional conduct. He explained that regulatory colleges rapidly investigate allegations of misconduct and that, if there is merit to the concern, the college imposes available interim sanctions and refers the case to law enforcement.¹³⁸

Ms. Close expressed confidence that regulators’ “tiered response” mechanisms were effective and indicated that, according to data from Ontario’s MAiD Death Review Committee (MDRC), “no MAID cases have been escalated to the police.” She affirmed that “Canada’s MAID system has real regulatory strengths, strong oversight, comprehensive monitoring and a layered ecosystem,” and that clinical guidance and coal face regulation are best placed to address MAID MD-SUMC. However, she recommended greater transparency in provincial oversight and continuous quality improvement.¹³⁹

Other witnesses raised concerns around professional oversight and discipline, notably regarding the effectiveness of the legal framework in sanctioning misconduct, ensuring

135 AMAD, [Evidence](#), 24 March 2026, 2110 (Jocelyn Downie).

136 AMAD, [Evidence](#), 27 April 2026, 1945 (Douglas Grant). See Federation of Medical Regulatory Authorities of Canada, Correspondence submitted to AMAD, 24 March 2026.

137 AMAD, [Evidence](#), 24 March 2026, 2010 (Mona Gupta); AMAD, [Evidence](#), 24 March 2026, 2110 (Jocelyn Downie); and AMAD, [Evidence](#), 27 April 2026, 1925 (Gordon Gubitz).

138 AMAD, [Evidence](#), 27 April 2026, 1955, 2005, 2010 (Douglas Grant).

139 AMAD, [Evidence](#), 27 April 2026, 1935, 2005, 2010, 2015 (Eliana Close).

proper interpretations of criteria or safeguards, and balancing access against protection.¹⁴⁰ These issues are discussed below.

Eligibility Criteria and Safeguards: Balancing Access and Protection

Some witnesses asserted that no additional legislative safeguards are required.¹⁴¹ Dr. van Veen spoke approvingly of Canada's two-track framework.¹⁴² Others stated that the safeguards were insufficient or that no safeguards could possibly mitigate the concerns raised.¹⁴³

Certain witnesses expressed misgivings stemming from what they perceive to be a lack of adequate safeguards for MAID MD-SUMC,¹⁴⁴ or from potential "inter-assessor variability"¹⁴⁵ in the interpretation of eligibility criteria and safeguards.¹⁴⁶ Related issues that were raised include assessors who may be "interpreting the law liberally,"¹⁴⁷ the potentially disproportionate provision of MAID by "a small number of permissive clinicians"¹⁴⁸ and "doctor shopping."¹⁴⁹ Ms. Lawley, representing Health Canada, also confirmed that MAID assessments are not shared across jurisdictions and that practitioners are not required to reach across jurisdictions; when asked if prior denials must be considered by a later assessor, she answered that she was unaware of whether that was part of the MAID assessor checklist.¹⁵⁰ Dr. Wilbert van Rooij encouraged the

140 AMAD, [Evidence](#), 14 April 2026, 2035 (Ramona Coelho); AMAD, [Evidence](#), 14 April 2026, 2035 (Karin Neufeld); and AMAD, [Evidence](#), 21 April 2026, 1925 (John Maher).

141 AMAD, [Evidence](#), 21 April 2026, 2120 (Daphne Gilbert); and AMAD, [Evidence](#), 27 April 2026, 2010 (Eliana Close).

142 AMAD, [Evidence](#), 5 May 2026, 1845, 1905 (Sisco van Veen).

143 AMAD, [Evidence](#), 28 April 2026, 1940 (Neil Belanger); and AMAD, [Evidence](#), 28 April 2026, 2015 (Dr. Roderick McCormick, Professor, Thompson Rivers University, as an individual).

144 AMAD, [Evidence](#), 14 April 2026, 2040 (Karin Neufeld); AMAD, [Evidence](#), 24 March 2026, 2035 (K. Sonu Gaiind); and AMAD, [Evidence](#), 21 April 2026, 2030 (Krista Carr).

145 AMAD, [Evidence](#), 14 April 2026, 2015 (Ramona Coelho). See also AMAD, [Evidence](#), 5 May 2026, 1915 (Jim van Os).

146 AMAD, [Evidence](#), 14 April 2026, 2105 (Harvey Max Chochinov); AMAD, [Evidence](#), 14 April 2026, 2105 (Pierre Gagnon); and AMAD, [Evidence](#), 5 May 2026, 1955 (Alexander Schadenberg, Executive Director, Euthanasia Prevention Coalition).

147 AMAD, [Evidence](#), 21 April 2026, 2050 (Catherine Frazee).

148 AMAD, [Evidence](#), 24 March 2026, 2045 (Trudo Lemmens).

149 AMAD, [Evidence](#), 21 April 2026, 1840 (John Maher); and AMAD, [Evidence](#), 5 May 2026, 2020 (Alexander Schadenberg).

150 AMAD, [Evidence](#), 14 April 2026, 1850 (Sarah Lawley).

committee to listen to clinicians “who have seen safeguards stretch, criteria soften and procedure replace presence.”¹⁵¹

Christopher Lyon expressed serious concerns around the adequacy of laws surrounding MAID and their interpretation by assessors.¹⁵² He described what he viewed as his father’s wrongful death by MAID and called British Columbia’s system “a pinball machine of deflection among colleges, police and coroners.”¹⁵³

Alicia Duncan told the committee that the circumstances surrounding her mother’s death by MAID show that Canada is not ready for the expansion. In her experience, the framework does not allow families to intervene in a crisis, to subsequently determine legal compliance or to verify oversight and accountability.¹⁵⁴

Michelle Hewitt, of Disability Without Poverty, recounted her husband Victor’s death from MAID, an experience she found painful and undignified. In her view, the assessors had been lax in complying with the criteria. She added that “[t]he current MAID program is severely broken.”¹⁵⁵

Dr. Maher described what he considered to be a case of illegal MAID provision.¹⁵⁶ He testified that, given the clinical reality, safeguards are “fanciful” and “going to fail.”¹⁵⁷

Alexander Schadenberg, of the Euthanasia Prevention Coalition, asserted that, rather than expanding MAID,

Parliament needs to examine how Canada’s euthanasia law is actually functioning. How has the law been implemented? Is it achieving its intended outcomes? Are there abuses of the law based on its original intention? Does the law require amendments?¹⁵⁸

151 AMAD, [Evidence](#), 5 May 2026, 1845 (Dr. Wilbert van Rooij, Psychiatrist, as an individual).

152 AMAD, [Evidence](#), 21 April 2026, 1830, 1910 (Dr. Christopher Lyon, Visiting Research Fellow, Centre for Death and Society, University of Bath, as an individual).

153 AMAD, [Evidence](#), 21 April 2026, 1830 (Christopher Lyon).

154 AMAD, [Evidence](#), 5 May 2026, 1945 (Alicia Duncan, as an individual).

155 AMAD, [Evidence](#), 21 April 2026, 2005 (Dr. Michelle Hewitt, Board Chair, Disability Without Poverty).

156 AMAD, [Evidence](#), 21 April 2026, 1845 (John Maher). See also AMAD, [Evidence](#), 14 April 2026, 2020 (Ramona Coelho).

157 AMAD, [Evidence](#), 21 April 2026, 1850 (John Maher).

158 AMAD, [Evidence](#), 5 May 2026, 1955 (Alexander Schadenberg).

Socio-economic Vulnerabilities

The committee heard that issues identified within the current MAID framework may foreshadow problems flowing from a future expansion, especially regarding particular vulnerabilities.

Dr. Coelho cautioned that cases examined by the MDRC “demonstrate premature eligibility, inadequate safeguards and a failure to address suffering before ending lives.” She reported that MDRC statistics “reveal that track 2 cases reflect high social vulnerability and untreated mental illness.” In her view, these factors mean that, “[a]lthough framed as a choice, MAID can allow structural coercive influences to push people towards death.”¹⁵⁹

Professor Downie noted that the MDRC does not assess for legal compliance and that its reports do not reflect consensus or make findings but, instead, present various members’ views.¹⁶⁰

Dr. Gandham was among those witnesses who raised concerns about structural vulnerabilities and their potential role in obscuring the cause of suffering in eligibility assessments:

Requests for death don’t arise in a vacuum. They may emerge in the context of trauma, poverty, isolation, inadequate housing, long waits [sic] for treatment, and lack of access to care and supports. ... In such cases, the suffering may be real, but its drivers may be remediable through social response rather than death as a medical intervention.¹⁶¹

Some witnesses feared that systemic vulnerabilities, inequities and inadequate access to health and social supports would have the effect of complicating the irremediability assessment or denying a person meaningful alternatives to MAID.¹⁶² The committee also heard that “systemic inequalities such as racism, poverty, homelessness and others can worsen mental health.”¹⁶³

159 AMAD, [Evidence](#), 14 April 2026, 1945 (Ramona Coelho). See also AMAD, [Evidence](#), 24 March 2026, 2045 (Trudo Lemmens); and Ontario, Ministry of the Solicitor General, Office of the Chief Coroner, [MAiD Death Review Committee Report 2024 – 3: Navigating Vulnerability in Non-Reasonably Foreseeable Natural Deaths](#).

160 AMAD, [Evidence](#), 24 March 2026, 2120 (Jocelyn Downie).

161 AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham). See also AMAD, [Evidence](#), 21 April 2026, 1840 (John Maher).

162 AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham); and AMAD, [Evidence](#), 21 April 2026, 2005 (Krista Carr). See also AMAD, [Evidence](#), 21 April 2026, 2035 (Michelle Hewitt).

163 AMAD, [Evidence](#), 27 April 2026, 2125 (Kevin Young).

Some witnesses highlighted specific populations. Professor Trudo Lemmens pointed to the potential risks faced by “people with intersecting disabilities.”¹⁶⁴ Krista Carr asserted that “Track 2 MAID applies only to persons with disabilities who are not dying” and that it is incompatible with Canada’s domestic and international human rights obligations. Alongside certain other witnesses, she noted the recommendation, put forth by the United Nations (UN) Committee on the Rights of Persons with Disabilities,¹⁶⁵ that Canada repeal Track 2 MAID, including for MI-SUMC.¹⁶⁶ Professor Gilbert questioned the extent to which that UN report was balanced and urged the committee to prioritize objective research.¹⁶⁷

Dr. Gaind indicated that, among those who have received MAID under Track 2, the evidence shows “signals of marginalization” and a higher proportion of women than men. In his opinion, “[a]ll these things would get even worse if MAID was provided for mental illness and addictions.”¹⁶⁸

Professors Elizabeth Sheehy and Isabel Grant testified that “[i]f MAID is extended to those whose sole disabling condition is mental illness, it will disproportionately end the lives of mentally ill women, just as track 2 already disproportionately ends the lives of disabled women.”¹⁶⁹ According to Professor Sheehy, Health Canada data shows that approximately 59% of all Track 2 deaths in 2022 and 2023 were women, as were 57% in 2024. She also highlighted a link between male violence and mental illness and suicidality in women, criticizing the lack of Canadian data on the role of trauma in MAID requests. She concluded that “Canada’s resources should be focused on providing better supports for women with mental illness to escape male violence and to live dignified lives.”¹⁷⁰

164 AMAD, [Evidence](#), 24 March 2026, 2045 (Trudo Lemmens).

165 United Nations, Committee on the Rights of Persons with Disabilities, [Concluding observations on the combined second and third periodic reports of Canada](#), 15 April 2025.

166 AMAD, [Evidence](#), 21 April 2026, 2005 (Krista Carr). See also AMAD, [Evidence](#), 24 March 2026, 2045 (Trudo Lemmens); AMAD, [Evidence](#), 14 April 2026, 1950 (Ramona Coelho); AMAD, [Evidence](#), 21 April 2026, 2105 (Elizabeth Sheehy, Professor Emerita of Law, University of Ottawa, as an individual); AMAD, [Evidence](#), 28 April 2026, 1935 (Neil Belanger); and AMAD, [Evidence](#), 5 May 2026, 1955 (Alexander Schadenberg).

167 AMAD, [Evidence](#), 21 April 2026, 2135 (Daphne Gilbert). However, see also AMAD, [Evidence](#), 21 April 2026, 2135 (Isabel Grant, University Killam Professor, University of British Columbia, as an individual).

168 AMAD, [Evidence](#), 24 March 2026, 1940 (K. Sonu Gaind).

169 AMAD, [Evidence](#), 21 April 2026, 2105 (Elizabeth Sheehy).

170 AMAD, [Evidence](#), 21 April 2026, 2105, 2110 (Elizabeth Sheehy).

Ms. Carr stated that “the data we have on track 2 MAID tells us that the people accessing track 2 MAID are disproportionately women, indigenous, living in poverty, low income and isolated, and they feel they’re a burden on their families.”¹⁷¹

Other witnesses highlighted different elements or interpretations of the data. According to Dr. Gupta, Health Canada’s data demonstrates “that MAID is accessed to a greater extent by people who are better off, who are white and who are in better social situations.”¹⁷² In echoing these conclusions, Professor Gilbert and Dr. Green pointed to recent research.¹⁷³ Professor Gilbert added that the proportion of women receiving MAID “tracks with the epidemiology of populations with chronic conditions. Women are more likely to develop these conditions and less likely to die from them.”¹⁷⁴

Professor Downie stated that Health Canada data on all MAID provisions since 2016 “show that socio-economic vulnerabilities and marginalization are not drivers of requests for MAID.” She added that, according to this data, “well over 90% of people who access MAID and have a disability do have access to disability supports and services.”¹⁷⁵

Indigenous Peoples

An official from the federal health department highlighted Health Canada’s consultation and resulting report on Indigenous perspectives regarding end-of-life care and MAID. She also noted the government’s continued engagement with Indigenous partners.¹⁷⁶

The committee heard from Neil Belanger, representing Indigenous Disability Canada (IDC). He described IDC’s work with people whose medical and social needs had not been met and who had been approved for Track 2 MAID. In his view, a decision to contemplate or receive MAID that is spurred by a lack of supports is not a voluntary, uncoerced act. He

171 AMAD, [Evidence](#), 21 April 2026, 2100 (Krista Carr). See also AMAD, [Evidence](#), 21 April 2026, 2105 (Elizabeth Sheehy).

172 AMAD, [Evidence](#), 24 March 2026, 2015 (Mona Gupta). See also AMAD, [Evidence](#), 27 April 2026, 1840 (Lilian Thorpe).

173 AMAD, [Evidence](#), 21 April 2026, 2120 (Daphne Gilbert); and AMAD, [Evidence](#), 27 April 2026, 1930 (Stefanie Green). See James Downar and Kieran L. Quinn, “Is Structural Marginalization Driving Medical Assistance in Dying (MAiD) in Canada? Interpreting Observational Data, Social Context, and Regulatory Reports,” [Canadian Journal of MAiD](#), Vol. 1, No. 1, Fall 2025.

174 AMAD, [Evidence](#), 21 April 2026, 2120 (Daphne Gilbert).

175 AMAD, [Evidence](#), 24 March 2026, 2040, 2125 (Jocelyn Downie). See Health Canada, [Sixth Annual Report on Medical Assistance in Dying in Canada](#), November 2025.

176 AMAD, [Evidence](#), 14 April 2026, 1910 (Sarah Lawley). See Health Canada, [Indigenous perspectives on end-of-life care, including medical assistance in dying: What we heard](#), December 2025.

indicated that funding in First Nations communities is often insufficient to address mental health issues and that the Health Canada consultation had garnered little uptake among Indigenous participants. His sole recommendation was “that we provide quality, adequate and timely services to persons with mental illness as the sole underlying condition and to persons, indigenous people, with disabilities.”¹⁷⁷

Professor Roderick McCormick saw the expansion of MAID as an “abdication of responsibility by the Government of Canada”:

Instead of making every effort to provide the range of mental health services needed by indigenous people to overcome their pain, Canada is instead imposing upon them the burden of deciding whether or not they should choose a government-sanctioned and medically sanctioned permanent solution to what could easily be a temporary problem.¹⁷⁸

Professor McCormick described the numerous factors contributing to make “indigenous people ... one of the most vulnerable sectors of Canadian society,” such as a history of colonization and ongoing oppression, minimal access to opportunities and services, and disproportionately high rates of unresolved trauma, illness and suicide.¹⁷⁹ He also viewed MAID as being “culturally biased ... , in that it emphasizes the individual’s right to autonomy and choice without taking others into consideration.”¹⁸⁰

Persons with Disabilities and Lived Experience

Professor McKinnon urged the committee to consider Canadians who, like her, “will feel at risk and unsafe should this legislation be enacted.”¹⁸¹

Gabrielle Peters pointed to a study finding “that support for euthanasia on the basis of mental illness was positively correlated with holding attitudes of stigma towards people with mental illness.” She asserted that a faulty understanding of disability rights was being invoked in the name of expanding MAID and that the expansion must be halted.¹⁸² Krista Carr reported that the people with whom Inclusion Canada works “feel ... that the availability of track 2 MAID and the further expansion of it embeds stereotypes and is

177 AMAD, [Evidence](#), 28 April 2026, 1935, 1955, 2005, 2010 (Neil Belanger).

178 AMAD, [Evidence](#), 28 April 2026, 1940 (Roderick McCormick).

179 Ibid. See also AMAD, [Evidence](#), 27 April 2026, 2125 (Kevin Young); and AMAD, [Evidence](#), 28 April 2026, 1955 (Neil Belanger).

180 AMAD, [Evidence](#), 28 April 2026, 1940 (Roderick McCormick).

181 AMAD, [Evidence](#), 27 April 2026, 1835 (Margaret McKinnon).

182 AMAD, [Evidence](#), 21 April 2026, 1950 (Gabrielle Peters).

discriminatory about their lives and their lives not being worth living or being worth saving.”¹⁸³

Helen Long, representing Dying with Dignity Canada, read out to the committee statements from people with mental illness who support MAID MI-SUMC, including the following:

- From John Scully –

I suffer from severe mental illness including incurable depression, incurable post-traumatic stress disorder, and incurable anxiety disorder. I was first diagnosed 30 years ago and since then I have been admitted to seven psychiatric hospitals, I have undergone every possible treatment and taken every medication known to science, including all the drugs developed since 1950. To this day, none have had any positive effects on me, and some have had dangerous effects.¹⁸⁴

- From Savannah Meadows –

I’m sure you can understand that some mental health issues are so severe and the pain they cause so great that they cannot be effectively treated or cured. When a person is in immense mental pain and no treatment can help them, under the current system people are left to suffer grievously, which is cruel and unusual punishment.¹⁸⁵

- From Claire Elyse Brosseau –

I’ve been treated for 35 years. Some people don’t respond to treatment. That’s a medical reality, not a philosophical debate. Broad assumptions...and guess work isn’t protecting us, but rather people’s feelings. It excludes us. Equality doesn’t mean special restrictions. Speculation isn’t lived experience.¹⁸⁶

Constitutional Considerations

Various witnesses raised constitutional considerations when discussing the advisability of expanding or restricting MAID. It was also noted that constitutional legal challenges

183 AMAD, [Evidence](#), 21 April 2026, 2025 (Krista Carr).

184 AMAD, [Evidence](#), 5 May 2026, 1950 (Helen Long).

185 Ibid.

186 Ibid.

are underway,¹⁸⁷ with some witnesses emphasizing the heavy burden borne by litigants in such cases.¹⁸⁸

For certain witnesses, the risk of discrimination lies in the anticipated expansion of MAID or even in the availability of Track 2,¹⁸⁹ whereas for others such discrimination would result from maintenance of the exclusion.¹⁹⁰

An official from the federal Department of Justice told the committee that “both permitting and prohibiting MAID can be in conformity with the charter, be it section 7 or section 15.”¹⁹¹ Section 15 guarantees equality rights, including the right of individuals to the equal protection and equal benefit of the law without discrimination. Referring the committee to the government’s Charter statements,¹⁹² the official added:

The Supreme Court of Canada noted in *Carter* that Parliament has leeway under the charter in deciding how to balance the competing interests engaged by MAID. The difficult question of whether or when to permit the provision of MAID on the basis of mental health alone is one that can be answered in different ways in conformity with the charter.¹⁹³

Another Department of Justice representative also indicated that MAID MD-SUMC has not been examined by a court through the lens of current legislation and that the Supreme Court had noted, in *Carter*, that its position reflected the facts of that case, which did not involve a mental disorder.¹⁹⁴

187 AMAD, [Evidence](#), 24 March 2026, 2135 (Jocelyn Downie); AMAD, [Evidence](#), 21 April 2026, 2050 (Catherine Frazee); AMAD, [Evidence](#), 21 April 2026, 2125 (Daphne Gilbert); AMAD, [Evidence](#), 21 April 2026, 2145 (Isabel Grant); and AMAD, [Evidence](#), 28 April 2026, 2015 (Neil Belanger).

188 AMAD, [Evidence](#), 21 April 2026, 2145 (Daphne Gilbert); and AMAD, [Evidence](#), 5 May 2026, 2035 (Helen Long).

189 AMAD, [Evidence](#), 24 March 2026, 1940 (K. Sonu Gaid); and AMAD, [Evidence](#), 21 April 2026, 2005 (Krista Carr).

190 AMAD, [Evidence](#), 24 March 2026, 1945 (Mona Gupta); AMAD, [Evidence](#), 24 March 2026, 2040 (Jocelyn Downie); and AMAD, [Evidence](#), 21 April 2026, 2100 (Daphne Gilbert).

191 AMAD, [Evidence](#), 14 April 2026, 1905 (Kimberly Gibner).

192 AMAD, [Evidence](#), 14 April 2026, 1925 (Kimberly Gibner); Government of Canada, [Bill C-7: An Act to amend the Criminal Code \(medical assistance in dying\) – Charter Statement](#), 21 October 2020; Government of Canada, [Bill C-39: An Act to amend An Act to amend the Criminal Code \(medical assistance in dying\) – Charter Statement](#), 15 February 2023; and Government of Canada, [Bill C-62: An Act to amend An Act to amend the Criminal Code \(medical assistance in dying\), No. 2 – Charter Statement](#), 8 February 2024.

193 AMAD, [Evidence](#), 14 April 2026, 1845 (Kimberly Gibner).

194 AMAD, [Evidence](#), 14 April 2026, 1930 (Julia Nicol, Counsel, Criminal Law Policy Section, Department of Justice).

Professor Downie affirmed that the current legal framework is sufficient and that regulatory readiness has been met, such that “the answer from a legal perspective about whether to allow MAID MI-SUMC was and remains robustly ‘yes.’” In her view, maintaining the exclusion would violate the section 7 and 15 Charter rights of persons with mental illness. She reasoned that the Supreme Court had held in *Carter* “that a ban on MAID is unconstitutional if it prohibits access for those with a grievous and irremediable medical condition, including an illness, disease or disability, and mental illness falls within this category.”¹⁹⁵ She pointed to the rulings in *E.F.* and *Truchon* as further confirming this interpretation.¹⁹⁶ Professors Downie and Gilbert also referred to the Supreme Court’s decision in *Ontario (Attorney General) v. G*¹⁹⁷ in support of the position that “a blanket ban on access to MAID MI-SUMC unjustifiably violates section 15 of the charter by failing to allow for individualized assessments.”¹⁹⁸

Professor Lemmens asserted that MAID MI-SUMC is not constitutionally required. He stated that the *Carter* case did not involve persons whose sole underlying medical condition was a mental disorder and that the judgment referred to end-of-life decision-making. He also questioned the weight to be attributed to the *E.F.* decision and the relevance of the *Truchon* ruling in the context of mental illness.¹⁹⁹

According to Professor Kerri Froc, “the charter does not require extension of MAID to mental illness as a sole underlying condition. *Carter* does not establish that requirement and section 15 does not compel it.” She stated that the MAID provisions create “a limited exemption from the criminal law” and that “[c]haracterizing that exemption as a benefit would be a significant and novel extension of section 15.” In her view, if the committee and Parliament “decide that mental illness as the sole underlying condition presents special problems of prognosis, irremediability and suicidality, then drawing a distinction on that basis is not necessarily going to be found to be discriminatory by a court.”²⁰⁰

By contrast, under Professor Gilbert’s analysis, “[t]he exclusion of individuals who would otherwise qualify for MAID but for the fact that their grievous and irremediable condition

195 AMAD, [Evidence](#), 24 March 2026, 2040, 2125 (Jocelyn Downie). See also AMAD, [Evidence](#), 27 April 2026, 2000 (Eliana Close).

196 AMAD, [Evidence](#), 24 March 2026, 2040 (Jocelyn Downie).

197 [Ontario \(Attorney General\) v. G](#), 2020 SCC 38.

198 AMAD, [Evidence](#), 24 March 2026, 2040 (Jocelyn Downie). See also AMAD, [Evidence](#), 21 April 2026, 2120, 2125 (Daphne Gilbert); and AMAD, [Evidence](#), 27 April 2026, 2000 (Eliana Close).

199 AMAD, [Evidence](#), 24 March 2026, 2045, 2055 (Trudo Lemmens). See also AMAD, [Evidence](#), 21 April 2026, 2110, 2115 (Dr. Kerri Froc, Associate Professor, University of New Brunswick, as an individual).

200 AMAD, [Evidence](#), 21 April 2026, 2055, 2130 (Kerri Froc).

is a mental illness is discriminatory and violates section 15 of the charter.” She affirmed that “[t]o suggest that an entire category of competent adults should be denied a legal medical service is profoundly discriminatory.”²⁰¹

Dr. Gandham explained that

[r]ecognizing this suffering is one of the reasons that many support MAID where mental disorder is a sole underlying condition. The potential benefit, ethically speaking, is the respect for autonomy and also equal treatment. If grievous and irremediable suffering is the foundation of MAID eligibility, some argue it would be discriminatory to categorically exclude those whose suffering is solely from mental illness.²⁰²

Nevertheless, Dr. Gandham considered that “the risks of proceeding [with the expansion of MAID] currently outweigh the potential benefits.”²⁰³

Professor Downie predicted the following consequences of not proceeding with the expansion:

What will happen if there is an extension or an exclusion is that people will die by suicide. They will go to Switzerland because they can access it there, or they will not get MAID in either way and will continue to experience enduring and intolerable suffering caused by a serious and incurable disease. They just have to have that suffering.

The consequences for the government are to end up in court.²⁰⁴

INTERNATIONAL CONTEXT

Some witnesses drew on international experiences to comment on Canada’s approach or on outcomes that may flow from the decision to lift the exclusion or not.

According to Dr. Gupta, other jurisdictions have concluded that “[t]here is no justification on clinical, ethical or legal grounds to exclude all people with mental disorders from the possibility of accessing assisted dying.”²⁰⁵

Dr. van Veen summarized the decades-long history of psychiatric MAID in the Netherlands. He noted that psychiatric MAID remains relatively rare, at around 2% of all

201 AMAD, [Evidence](#), 21 April 2026, 2100, 2105 (Daphne Gilbert).

202 AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham).

203 AMAD, [Evidence](#), 27 April 2026, 2120 (Sandip Singh Gandham).

204 AMAD, [Evidence](#), 24 March 2026, 2120 (Jocelyn Downie).

205 AMAD, [Evidence](#), 24 March 2026, 1945 (Mona Gupta).

cases. He was supportive of a limited access to psychiatric MAID for a small number of patients, in compliance with specific “due diligence criteria,” as he found it “hard to justify excluding patients with psychiatric disorders whose suffering can be immense or, in other words, unbearable.”²⁰⁶

Dr. Jim van Os told the committee that the Dutch experience “offers a warning for Canada” not to expand. He stated that, “[u]nder Dutch law, physicians must agree that there are no reasonable options,” such that “[e]uthanasia is, in principle, the very last resort.” He contrasted this requirement with his characterization of Canadian law: “In Canada, patient choice trumps the physician’s professional judgment, so a doctor cannot insist that other options be tried first.” In his view, “[t]hat single difference will ... drive Canadian numbers beyond ours.”²⁰⁷ Some witnesses pointed to research by Dr. Scott Kim estimating that 2,500 to 5,000 MAID MD-SUMC requests would be made in Canada each year, with approximately half being approved.²⁰⁸

Dr. van Os responded to questions about a recently published article²⁰⁹ he had co-authored with Dr. Wilbert van Rooij, another witness who shared similar concerns. Both highlighted increases in euthanasia requests and euthanasia delivered to young persons under 30 years of age, relying on statistics from the Regional Euthanasia Review Committees in the Netherlands.²¹⁰

Dr. van Os explained that, whereas 3% of applications by young people result in MAID, “there’s been a growth of about 500% over five years in the number of young people getting MAID.”²¹¹ This data, also cited in his co-authored paper, is taken from the Regional Euthanasia Review Committees’ *Annual Report 2024*, which notes that the number of psychiatric euthanasia cases increased from 2 in 2011 to 138 in 2023,

206 AMAD, [Evidence](#), 5 May 2026, 1845, 1905 (Sisco van Veen).

207 AMAD, [Evidence](#), 5 May 2026, 1835 (Jim van Os). See also AMAD, [Evidence](#), 24 March 2026, 2045 (Trudo Lemmens).

208 AMAD, [Evidence](#), 14 April 2026, 2045, 2100 (Harvey Max Chochinov). See Scott Y. H. Kim, [Regarding Follow-up on Recommendation 13 of the Second Report of the Special Joint Committee on Medical Assistance in Dying on Preparedness for MAID for Mental Disorders as a Sole Underlying Medical Condition \(MAID MD-SUMC\)](#), Brief submitted to AMAD, 16 November 2023.

209 Jim Van Os, Wilbert van Rooij and Mark S. Komrad, “[Psychiatric Euthanasia in the Netherlands: Young People, Procedural Medicine, and the Limits of Psychiatry](#),” *Psychiatric Times*, 5 March 2026.

210 Regional Euthanasia Review Committees, [Annual report 2024](#), March 2025.

211 AMAD, [Evidence](#), 5 May 2026, 1925 (Jim Van Os).

followed by a further rise to 219 cases in 2024, representing an increase of roughly 60% in a single year.²¹² Of the 219 cases, 30 concerned people aged between 18 and 30.²¹³

According to Dr. van Os, most of those who request psychiatric euthanasia are traumatized, marginalized and living in poverty, and women are more likely than men to request psychiatric euthanasia.²¹⁴ Professor Sheehy also highlighted research finding that between 69% and 77% of those receiving psychiatric euthanasia in countries where it is allowed are women.²¹⁵

Furthermore, Dr. van Os pointed to an increase in suicide rates in the Netherlands, particularly among young women.²¹⁶ He testified that, according to his research, there is no inverse correlation between euthanasia and suicide rates and that “it’s not possible to say that euthanasia is necessary to prevent suicide”:

You have a number needed to treat of 10, and a number needed to harm of nine, meaning that 10 young people must undergo euthanasia to prevent one suicide, and nine die without any preventive purpose being served.²¹⁷

Dr. van Rooij described a reduction in the availability of psychiatric care in the Netherlands, alongside the normalization and acceleration of psychiatric euthanasia.²¹⁸

Ultimately, Dr. van Os recommended that Canada implement “a transparent public body for oversight with representatives of disability, palliative care, psychiatry” and Indigenous and lived-experience communities.²¹⁹

212 Regional Euthanasia Review Committees, [Annual report 2024](#), March 2025.

213 Ibid., p. 20.

214 AMAD, [Evidence](#), 5 May 2026, 1835, 1855 (Jim van Os).

215 AMAD, [Evidence](#), 21 April 2026, 2105 (Elizabeth Sheehy). See Marie E. Nicolini, Chris Gastmans and Scott Y. H. Kim, “[Psychiatric euthanasia, suicide and the role of gender](#),” *The British Journal of Psychiatry*, Vol. 220, No. 1, January 2022.

216 See also AMAD, [Evidence](#), 28 April 2026, 1830 (Brian Mishara).

217 AMAD, [Evidence](#), 5 May 2026, 1850 (Jim van Os).

218 AMAD, [Evidence](#), 5 May 2026, 1840, 1900 (Wilbert van Rooij).

219 AMAD, [Evidence](#), 5 May 2026, 1915 (Jim van Os).

CONCLUSIONS AND RECOMMENDATION

The committee's 2024 report underlined conflicting views on Canada's state of readiness at that time:

While some witnesses said Canada is clearly ready, others stated that preparations are still in progress, or that the state of the country's readiness for 17 March 2024 is difficult to ascertain. Still others felt that readiness for MAID MD-SUMC will never be attained.²²⁰

At the conclusion of the present review relating to the eligibility to receive MAID of persons whose sole underlying medical condition is a mental illness, the committee finds that this divergence of perspectives persists. Some witnesses asserted that Canada is or will be ready for the expected expansion on 17 March 2027. Others stated that the conditions for proceeding have yet to be met, including the establishment of evidence-informed, consensus-based criteria for determining irremediability and delineating between a reasoned MAID request and suicidal intent; the existence of adequately resourced mental health systems; or the presence of sufficiently stringent regulatory safeguards. Finally, for some, the expansion should never proceed, under any circumstances. Many recognized that these issues are difficult, challenging and consequential for Canadians.

Having heard of the significant complexities and risks, grave concerns and deep divisions that continue to accompany this issue, the committee identified four possible avenues forward for the Government of Canada:

- 1) Firstly, it could allow the expected repeal of the provision excluding MAID MI-SUMC to proceed, in accordance with existing legislation, thereby permitting persons whose sole underlying medical condition is a mental illness to become eligible to receive MAID.
- 2) Secondly, it could introduce legislation to further extend the exclusion of MAID MI-SUMC, for a definite or indefinite period.
- 3) Thirdly, it could introduce legislation to permanently prohibit MAID MI-SUMC.
- 4) Fourthly, if maintenance of the exclusion is contemplated, it could refer the matter to the Supreme Court for a ruling on the constitutionality of such an exclusion.

220 AMAD, [MAID and Mental Disorders: The Road Ahead](#), Third report, January 2024, p. 4.

The committee also notes that the continuing ambiguity surrounding questions of terminology – “mental illness” or “mental disorder” – would benefit from greater clarity and consensus.²²¹

Ultimately, the committee makes the following recommendation:

Recommendation 1

That the Government of Canada amend the *Criminal Code* to indefinitely exclude persons whose sole underlying medical condition is a mental illness from eligibility for medical assistance in dying.

221 Note for example that, “[i]f ‘mental disorder’ were to be excluded, then ‘major neurocognitive disorder’ – i.e., dementia—would also be excluded, because it is considered a diagnosable mental disorder”: AMAD, [Evidence](#), 24 March 2026, 2025 (Mona Gupta). See also Nicholas Dunn, [MAID MI-SUMC and the Ontology of Mental Disorder](#), Brief submitted to AMAD, 20 April 2026.

APPENDIX A LIST OF WITNESSES

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee’s [webpage for this study](#).

Organizations and Individuals	Date	Meeting
<p>As an individual</p> <p>Jocelyn Downie, Professor Emeritus, Faculties of Law and Medicine, Dalhousie University</p> <p>Dr. K. Sonu Gaind, Professor of Psychiatry, Faculty of Medicine, University of Toronto</p> <p>Dr. Mona Gupta, Full Clinical Professor, Department of Psychiatry and Addiction, Université de Montréal</p> <p>Dr. Trudo Lemmens, Professor and Scholl Chair in Health Law and Policy, Jackman Faculty of Law, University of Toronto</p>	2026/03/24	2
<p>As an individual</p> <p>Dr. Harvey Max Chochinov, Distinguished Professor of Psychiatry, University of Manitoba</p> <p>Dr. Ramona Coelho, Family Physician</p> <p>Dr. Pierre Gagnon, Psychiatrist</p> <p>Dr. Karin Neufeld, Psychiatrist and Chair of Department of Psychiatry, McMaster University</p>	2026/04/14	3
<p>Association des médecins psychiatres du Québec</p> <p>Dr. Guillaume Barbès-Morin, Psychiatrist</p> <p>Dr. Claire Gamache, Psychiatrist</p>	2026/04/14	3
<p>Department of Health</p> <p>Sarah Lawley, Assistant Deputy Minister, Health Policy Branch</p>	2026/04/14	3
<p>Department of Justice</p> <p>Kimberly Gibner, Deputy Assistant Deputy Minister, Policy Sector</p> <p>Julia Nicol, Counsel, Criminal Law Policy Section</p>	2026/04/14	3

Organizations and Individuals	Date	Meeting
As an individual	2026/04/21	4
Dr. Catherine Frazee, Professor Emerita, School of Disability Studies, Toronto Metropolitan University		
Dr. Kerri A. Froc, Associate Professor, University of New Brunswick		
Daphne Gilbert, Full Professor, University of Ottawa, Faculty of Law		
Isabel Grant, University Killam Professor, University of British Columbia		
Dr. Christopher Lyon, Visiting Research Fellow, Centre for Death and Society, University of Bath		
Elizabeth Sheehy, Professor Emerita of Law, University of Ottawa		
Disability Filibuster	2026/04/21	4
Gabrielle Peters, Co-Founder		
Disability Without Poverty	2026/04/21	4
Dr. Michelle Hewitt, Board Chair		
Inclusion Canada	2026/04/21	4
Krista Carr, Chief Executive Officer		
Ontario Association for ACT & FACT	2026/04/21	4
Dr. John Maher, Psychiatrist		
As an individual	2026/04/27	5
Dr. Eliana Close, End of Life Research Program, Australian Centre for Health Law Research, Queensland University of Technology		
Dr. Sandip Singh Gandham, Assistant Clinical Professor, Department of Family Medicine, University of Alberta		
Dr. Margaret McKinnon, Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University		
Dr. Jitender Sareen, Head of Psychiatry and Professor, Department of Psychiatry, University of Manitoba		
Dr. Lilian Thorpe, Full Professor, Department of Community Health and Epidemiology and Department of Psychiatry, University of Saskatchewan		

Organizations and Individuals	Date	Meeting
9-8-8: Suicide Crisis Helpline Dr. Allison Crawford, Chief Medical Officer	2026/04/27	5
Canadian Association of MAiD Assessors and Providers Dr. Stefanie Green, MAiD Provider Dr. Gordon Gubitz, MAiD Provider	2026/04/27	5
College of Physicians and Surgeons of Nova Scotia Dr. Douglas Grant, Registrar and Chief Executive Officer	2026/04/27	5
Ontario Hospital Association Melissa Prokopy, Vice-President, Policy and Advocacy Dr. Kevin Young, Vice-President, Medical Affairs and Chief of Staff, Waypoint Centre for Mental Health	2026/04/27	5
As an individual Dr. Roderick McCormick, Professor, Thompson Rivers University Prof. Brian Mishara, Director, Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices, Université du Québec à Montréal	2026/04/28	6
Centre for Addiction and Mental Health Dr. Sanjeev Sockalingam, Senior Vice-President, Education and Chief Medical Officer	2026/04/28	6
Indigenous Disability Canada Neil Belanger, Chief Executive Officer	2026/04/28	6
As an individual Alicia Duncan Dr. Jim van Os, Professor of Psychiatry Dr. Wilbert van Rooij, Psychiatrist Dr. Sisco van Veen, Psychiatrist	2026/05/05	7
Dying with Dignity Canada Helen Long, Chief Executive Officer	2026/05/05	7
Euthanasia Prevention Coalition Alexander Schadenberg, Executive Director	2026/05/05	7

APPENDIX B LIST OF BRIEFS

The following is an alphabetical list of organizations and individuals who submitted briefs to the committee related to this report. For more information, please consult the committee's [webpage for this study](#).

1, Anonymous Author - Auteure anonyme

Afifi, Dr. Tracie

Agyapong, Dr. Vincent

Ahmed, Dr. Adekunle Garba

Association for Reformed Political Action Canada

Birenbaum, Shelley

Bolton, Dr. James M.

Bolton, Dr. Shay-Lee

Cardus

Chochinov, Dr. Harvey Max

Coelho, Dr. Ramona

Downie, Dr. Jocelyn

Dumond, Stéphanie

Dunn, Dr. Nicholas

Dying with Dignity Canada

Ferrier, Dr. Catherine

Fisk, Dr. Derek

Friesen, Tyson

Fung, Dr. Kenneth

Gagnon, Dr. Pierre

Gaind, K. Dr. Sonu

Gobbi, Dr. Gabriella

Grant, Prof. Isabel

Gupta, Dr. Mona
Haak, Dr. Debra
Haggarty, Dr. Jack
Haggarty, Dr. John
Hall, Dr. Patricia
Hatcher, Dr. Simon
Husni, Dr. Mariwan
Inclusion Canada
Indigenous Disability Canada
Koka, Dr. Rayuda
Kim, Dr. Scott
King, Dr. Rebecca
LeBlanc, Arlene
Lyon, Dr. Christopher
Marrie, Dr. Ruth Ann
Moran, Sherry
National Association of Catholic Nurses - Canada
Neufeld, Dr. Karin
Noble, Dr. Sarah
Perera, Essence
Physicians' Alliance against Euthanasia
Ross, Dr. David A.
Roy-Desruisseaux, Dr. Jessika
Samaan, Dr. Zainab
Sareen, Dr. Jitender
Shannon, David
Sheehy, Prof. Elizabeth
Sinyor, Dr. Mark
Stein, Dr. Murray B.
Tang, Dr. Sephora

The Evangelical Fellowship of Canada

Turecki, Dr. Gustavo

William, Trevyna

Yatham, Dr. Lakshmi

MINUTES OF PROCEEDINGS

A copy of the relevant *Minutes of Proceedings* ([Meetings Nos. 2 to 8](#)) is tabled.

Respectfully submitted,

Hon. Yonah Martin and Marcus Powlowski
Co-Chairs

SUPPLEMENTARY OPINION OF SENATOR DALPHOND¹

THE QUESTION BEFORE US

It is not disputed that some people suffer from incurable mental disorders that cause them intolerable suffering. Should they be allowed to access medical assistance in dying (“MAID”) through Track 2, effective March 17, 2027?

MANDATE OF THE COMMITTEE

The committee’s mandate is set out in Bill [C-62](#), which entered into force on February 29, 2024, as follows: to conduct “[a] comprehensive review relating to the eligibility of persons whose sole underlying medical condition is a mental disorder to receive medical assistance in dying.” It is broader than the mandate given by the chambers in October 2023, which was limited to verifying the level of preparedness achieved for the safe and adequate application of MAID where mental disorder is the sole underlying medical condition.

The reconstituted committee held its first meeting on March 10, 2026. It later agreed on a tight timeline which would permit the tabling of its report to Parliament before the summer recess, so that the government would have the summer to formulate its position and draft legislation for consideration in the fall of 2026.

Some have criticized the fact that the Committee heard from more witnesses opposed to MAID eligibility for mental disorders, than from those in favor. In my view, the number of witnesses for or against a particular option is not significant. What matters are the established facts, the soundness of the premises used by experts to support their opinions, and the applicable principles, including legal ones.

I would add that the *Criminal Code* currently provides for MAID for mental disorders as of March 17, 2027. The Committee could therefore be expected to hear primarily from those who wish to change this and then decide whether action is warranted.

As noted in the report, Committee members were asked to choose between three possible recommendations to the government:

1. Allow the exclusion to expire on March 17, 2027;
2. Extend this exclusion; or
3. Permanently deny/prohibit access to MAID.

¹ Former trial and appellate court judge and member of the Senate and joint committees on MAID since 2020.

The majority of the committee members recommend that the government extend the exclusion indefinitely. I agree and would like to expand upon my position, given my dissenting opinion included in the Committee's January 2024 [report](#).

ESTABLISHED FACTS

(i) The Evolution of the Law Relating to MAID

In 2015, in *Carter v Canada (Attorney General)*, [2015 SCC 5](#), the Supreme Court of Canada ruled that section 7 of the *Canadian Charter of Rights and Freedoms* protects Canadians' right to make decisions regarding the end of their lives and that the provisions of the *Criminal Code* prohibiting physician-assisted death are unconstitutional.

The Court also said that MAID for persons with psychiatric disorders as a sole underlying condition did not fall within the parameters of its reasons despite arguments presented by the Attorney General of Canada on that issue.

In June 2016, Parliament adopted Government Bill [C-14](#), which amended the *Criminal Code* to allow access to MAID for people suffering from an irremediable illness and whose death is reasonably foreseeable (MAID, Track 1).

In *Truchon c Procureur général du Canada*, [2019 QCCS 3792](#), in the context of another constitutional challenge, the Superior Court of Québec concluded that access to MAID could not be restricted to those whose death is reasonably foreseeable. The court ordered that the *Criminal Code* and the *Act respecting end-of-life care* (Quebec) be amended accordingly. Neither the federal nor the provincial government appealed.

In October 2020, Bill [C-7](#) was introduced. It proposed allowing access to MAID for people who are not terminally ill but are suffering from an incurable condition that has become intolerable to them.

Bill [C-7](#) expressly excluded all individuals suffering solely from an incurable mental illness. The Senate adopted an amendment limiting the exclusion to 18 months (a sunset clause) to allow time for guidelines and appropriate training to be put in place.

On March 11, 2021, the House of Commons extended the sunset clause to 24 months and added a requirement for the ministers of Health and Justice to appoint a panel of experts to undertake "an independent review [...] respecting recommended protocols, guidance and safeguards to apply to requests made for medical assistance in dying by persons who have a mental illness".

On May 13, 2022, the Panel's [final report](#) was published. The Panel concluded that existing MAID Track 2 eligibility criteria and safeguards, buttressed by the existing laws, standards, and practices in related areas of healthcare, can provide an adequate structure for MAID where the sole underlying condition is a mental disorder. However, the Panel recommended that specialized training be made available to providers and assessors before allowing access.

In March 2023, through Bill [C-39](#), Parliament extended the sunset clause by one year, ending on March 17, 2024. Per the government, such an extension would help ensure health care system readiness by, among other things, allowing more time for the dissemination and uptake of key resources by the medical and nursing communities, including MAID assessors and providers.

On February 1, 2024, the government introduced Bill [C-62](#), which proposed extending the sunset clause for another three years, until March 17, 2027, and to direct the Committee, within two years of its coming into force, to conduct "[a] comprehensive review relating to the eligibility of persons whose sole underlying medical condition is a mental disorder to receive medical assistance in dying". Bill C-62 became law on February 29, 2024.

(ii) A Lack of Consensus Among Psychiatrists

MAID Track 2, based solely on the grounds of an irremediable mental disorder causing intolerable suffering, has been the subject of intense controversy in Canada since 2020, due in part to a lack of consensus among psychiatrists.

Some psychiatrists argue that suffering can always be alleviated, which prevents it from being viewed as irremediable. Others disagree.

On the other hand, all psychiatrists agree that several mental disorders are associated with suicidal ideation. For some, this makes it impossible to reliably determine whether the requisite consent has been given. For others, it is merely a factor that complicates the assessment of consent.

To assist clinicians, last March the Canadian Psychiatric Association released a [document](#) titled "Canadian Guidance on Medical Assistance in Dying (MAID): Evaluating the 'Grievous and Irremediable' Eligibility Criterion in Persons with Mental Disorders who Request MAID and Managing Suicide Risk during the Process for All MAID Eligibility Requests".

Despite publications such as that of the Canadian Psychiatric Association, in a [brief](#) submitted to the Committee on April 20, the chairs of psychiatry departments at several medical schools strongly recommended that the committee extend indefinitely the exclusion of mental disorders as the sole underlying medical condition from MAID access.

(iii) The Social Acceptability of MAID for Mental Disorders

Some committee members argue that there is not enough public acceptance. It is true that there are groups that are strongly opposed, many of whom were just as opposed to the introduction of Track 2.

In Quebec, in its December 2021 [report](#), the National Assembly's Select Committee on the Evolution of the *Act respecting end-of-life care* recommended against extending access to MAID to people whose sole medical condition is a mental disorder, on the grounds that this was consistent with the precautionary principle and the lack of medical and social consensus. In June 2023, the law was amended accordingly.

In Alberta, Bill 18, the [Safeguards for Last Resort Termination of Life Act](#), proposes to prohibit physician-assisted death solely on the grounds of mental disorder and to require, in all other cases, a prognosis of death within 12 months, thereby restricting Track 2.

Recent debates in the House of Commons on Private Member's Bill [C-218](#) show that some members of Parliament are inclined to amend the *Criminal Code* to prohibit MAID for individuals suffering solely from mental disorders.

In a [brief](#) before the Committee, the Association for Reformed Political Action claimed, based on a 2023 Angus Reid [poll](#), that 28% of Canadians support MAID for mental disorders, while 50% oppose it. Yet, a recent Angus Reid [poll](#) released on June 1, 2026, now shows more support (43%) than opposition (39%).

Lastly, according to [surveys](#) conducted in 2023 and 2026 by Environics Research for Dignity with Dying Canada, 80% of the 1,000 Canadians surveyed support access to Track 2 MAID for those suffering from an incurable and intolerable mental disorder.

Thus, the argument that MAID for mental disorders lacks social acceptability does not seem very convincing.

(iv) Readiness for the Provision of MAID for Mental Disorders

The [Ontario Hospital Association](#), which represents 135 hospitals of various sizes, believes that more time is needed to reach a consensus on diagnosis and to ensure the capacity and readiness of the hospital system.

Neither Alberta nor Quebec is prepared to allocate the necessary resources to approve MAID for mental disorders.

Finally, documents produced by Health Canada on meetings with provincial and territorial MAID officials indicate that levels of preparedness vary widely across the country.

In sum, the Canadian healthcare system is not yet ready to provide nationwide access to MAID for mental disorders.

RELEVANT LEGAL PRINCIPLES

In [Carter](#), the Supreme Court of Canada stated:

[115] [...] Based on the evidence regarding assessment processes in comparable end-of-life medical decision-making in Canada, the trial judge concluded that vulnerability can be assessed on an individual basis, using the procedures that physicians apply in their assessment of informed consent and decisional capacity in the context of medical decision-making more generally. Concerns about decisional capacity and vulnerability arise in all end-of-life medical decisionmaking. Logically speaking, there is no reason to think that the injured, ill, and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying. [...]

[116] As the trial judge noted, the individual assessment of vulnerability (whatever its source) is implicitly condoned for life-and-death decision-making in Canada. In some cases, these decisions are governed by advance directives, or made by a substitute decision-maker. Canada does not argue that the risk in those circumstances requires an absolute prohibition (indeed, there is currently no federal regulation of such practices). In A.C., Abella J. adverted to the potential vulnerability of adolescents who are faced with life-and-death decisions about medical treatment (paras. 72-78). Yet, this Court implicitly accepted the viability of an individual assessment of decisional capacity in the context of that case. We accept the trial judge's conclusion that it is possible for physicians, with due care and attention to the seriousness of the decision involved, to adequately assess decisional capacity.
[emphasis added]

In other words, the fact that members of a group are recognized as vulnerable does not justify ruling out the possibility of individual assessment.

In [Truchon](#), Justice Baudouin for the Superior Court of Québec (as she then was) wrote:

[466] From the evidence as a whole, the Court concludes as follows:

[...]

2. The physicians involved are able to assess the patients' capacity to consent and identify signs of ambivalence, mental disorders affecting or likely to affect the decision-making process, or cases of coercion or abuse;

3. The vulnerability of a person requesting medical assistance in dying must be assessed exclusively on a case-by-case basis, according to the characteristics of the person and not based on a reference group of so-called "vulnerable persons". Beyond the various factors of vulnerability that physicians are able to objectify or identify, the patient's ability to understand and to consent is ultimately the decisive factor, in addition to the other legal criteria; [...]

[emphasis added]

In [Ontario \(Attorney General\) v G](#), 2020 SCC 38, the Supreme Court of Canada dealt with a law that provided a person convicted of a sexual offence with the possibility of being removed from the sex offender registry, while denying any similar option to all individuals found not criminally responsible on account of mental disorder (NCRMD). The Court found that section 15 of the *Charter*, the equality guarantee, requires that these individuals must also have access to an exclusion mechanism, based on individualized assessments. The Court concluded that a blanket denial of potential exclusion for that group was unconstitutional. For the majority, Justice Karakatsanis wrote:

[74] I agree with the Court of Appeal that Christopher's Law is not minimally impairing of the s. 15(1) rights of those who were found NCRMD of a sexual offence and discharged. Christopher's Law itself includes mechanisms by which, after some form of individualized assessment of their circumstances, offenders who were not found NCRMD can be removed from the registry (free pardon), relieved of the obligation to report (free pardon and record suspension), or exempted from reporting in the first place (discharge under s. 730 of the Criminal Code). The inclusion of any method of exempting and removing those found NCRMD from the registry based on individualized assessment would be less impairing of their s. 15(1) rights and could actually increase the registry's effectiveness by narrowing its application to individuals who pose a greater risk to the community.

[emphasis added]

In the [Charter Statement](#) tabled in the House of Commons on February 15, 2023, the Minister of Justice acknowledged that Bill [C-39](#), by temporarily prohibiting access to MAID where the sole condition identified is a mental disorder, had the potential to engage liberty and security of

these individuals protected by section 7 of the *Charter*. It also had the potential to engage the right to equality under section 15 because the exclusion applies only to individuals who suffer from a mental disorder.

In the [Charter Statement](#) tabled in the House of Commons on February 8, 2024 regarding Bill [C-62](#), the Minister of Justice states that the additional three-year exclusion for this group was based on concerns regarding the complexity and risks inherent in granting MAID to these individuals, such as the difficulty of assessing decision-making capacity, the difficulty of predicting the long-term progression of a mental disorder compared to a physical illness, and the novelty of MAID in Canada, which means that the body of evidence and research is still evolving.

The committee's report focuses specifically on these issues.

RECOMMENDATION

I believe it would be unconstitutional to prohibit MAID for all individuals with a severe, irreversible mental disorder that cause them intolerable suffering but who are capable of giving free and informed consent, rather than to provide for a process to conduct individual assessment of a person's eligibility. I therefore cannot recommend this option to the government.

As for the option of allowing the sunset clause to expire in March 2027, I cannot support it. The additional complexity associated with mental disorders, combined with the need for consistent and standardized application to prevent inconsistencies, calls for the establishment of a mechanism to review assessors' work prior to any administration of MAID for mental disorders.

The review body could be provincial or pan-Canadian. It should include psychiatrists, psychologists, and legal experts who are not involved in requests for access to MAID or their evaluation. In short, a Track 3 is needed, or at the very least, a modified Track 2.

Consequently, I agree with the members of Parliament in recommending the government amend the *Criminal Code* to extend the exclusion of MAID for those whose sole underlying medical condition is a mental disorder for an indefinite period.

In the meantime, the [legal proceedings](#) initiated in August 2024 before the Ontario Superior Court of Justice by Claire Elyse Brosseau, with the support of Dignity with Dying Canada, will continue. This will allow for a rigorous assessment of the factual evidence and expert opinions, an exercise that cannot be carried out by a parliamentary committee or in the context of a reference to the Supreme Court of Canada.

Unfortunately, such a constitutional challenge is a long, complex, and expensive process. The *Carter* challenge lasted for four years, even though the trial was held on an expedited basis.

Throughout this legal process, which could ultimately reach the Supreme Court of Canada, I am well aware that prolonging the ban could cause intolerable suffering for certain individuals who are fully capable of making decisions, have exhausted all other options, and now wish to have access to MAID.

In a similar situation, these individuals might consider filing constitutional challenges, as Ms. Brosseau has just done. I would like to point out that in 2016, following the *Carter* decision and prior to the passage of Bill C-14, the Alberta Court of Appeal, in *Canada (Attorney General) v E.F.*, [2016 ABCA 155](#), granted access to MAID to a person suffering solely from a mental disorder.

This is the reasonable compromise that is called for in this case, rather than granting access to Track 2 as early as March 17, 2027, which, upon careful consideration does not appear to provide sufficient safeguards to ensure access to MAID where the sole underlying medical condition is a mental disorder only to those whose condition is irreversible and intolerable, and where the election reflects free and informed consent.

The Special Joint Committee on Medical Assistance in Dying

Dissenting Report – Honourable Senator Dr. Rosemary Moodie, MD, Honourable Senator Pamela Wallin, O.C., and Honourable Senator Kristopher Wells, PhD

June 16, 2026

The following dissenting opinion is authored by three independent senators who participated in the Special Joint Committee on Medical Assistance in Dying between Tuesday March 10, 2026, and Tuesday May 5, 2026.

This dissenting opinion is also supported by the Honourable Senator Dr. Flordeliz "Gigi" Osler who participated in some meetings as an alternate. Senator Osler is a medical doctor with personal and professional expertise in medical training who previously served as the President of the Canadian Medical Association. Senator Moodie is a medical doctor, also with personal and professional expertise in medical training and the delivery of specialized intensive care and complex medical care, an academic physician and a university professor. Senator Wallin who was a member of the original MAiD committee and Senator Wells was a tenured university professor and Canada Research Chair.

Our Recommendation

That the Government of Canada not accept the majority report and recommendations from the Special Joint Committee on Medical Assistance in Dying and instead ask the Government to make a direct reference to the Supreme Court of Canada to clarify the law regarding the extension of access to MAiD for persons with a mental disorder as the sole underlying medical condition

Rationale

This dissenting opinion results from the highly irregular and flawed process by which the Special Joint Committee Medical Assistance in Dying conducted its business and on the poor quality of empirical medical, scientific, and research data that was presented at the Committee.

At the outset, the Committee agreed to focus its scope on the readiness of the provincial and territorial healthcare systems as well as the integrity of the current safeguards in place to mitigate any abuse or misuse of the MAiD eligibility process.

Of the invited 44 witnesses that the Committee heard, more than two-thirds of the witnesses have been publicly opposed to extending MAiD for persons with a mental illness. Furthermore, although there were ample witness suggestions presented to the committee co-chairs that could provide perspective on Canada's readiness based on their lived experiences, few were invited to appear. This bias was widely reported in the national media and, in our view, rightly calls into question the credibility of the committee process and the final report. Simply put, a flawed and biased process cannot be relied upon and has resulted in a report that lacks rigor and credibility. We stress this is not the way parliamentary committees are designed to operate. Concerns were repeatedly raised by Senators about witness selection and how the committee sessions were managed but these concerns were ignored. Even in the final stages, Liberals and the CPC joined forces to railroad the committee process and use their joint voting clout to vote down a reference to the Supreme Court to rule on this matter.

The failure to ensure a fair and balanced perspective has resulted in significant criticism from advocates, legal experts, and persons with lived experience regarding the impartiality of the Committee's study and a lack of empirical and peer-reviewed evidence to substantiate the Committee's findings. Noted advocates with lived experience like Claire Brosseau and legal experts like Professor Jocelyn Downie, have all publicly indicated their strong opposition to the way in which the Committee has gone about its process.

The majority of the witnesses invited to appear before the Committee were drawn from clinical, psychiatrist, and advocacy communities that hold well documented and categorical public objections to MAiD MD-SUMC. Witnesses that could have provided evidence in support of a carefully regulated extension, including clinicians with direct experience assessing and approving MAiD requests, or the Canadian Association of Psychiatrists who have developed guidance for MAiD practitioners, were notably absent from the invited witness list, despite being repeatedly recommended to appear

This bias compromised the evidentiary foundation of the Committee's findings. Witnesses opposing extension repeatedly cited concerns about diagnostic uncertainty, the difficulty of establishing irremediability in the case of mental illness, and systemic gaps in how governments across Canada provide mental health services, particularly for vulnerable populations like those with a physical disability. Although these concerns are legitimate and should be carefully considered, they were not brought forward to practitioners and clinicians who provide MAiD services regularly.

The Committee heard little evidence from forensic psychiatrists, MAiD assessors, or bioethicists who have studied and can present comprehensive evidence that the current safeguards for MAiD are designed to permit access for individuals with treatment-

resistant mental illness and who meet the high threshold to access MAiD established in Bill C-14 and later in Bill C-62.

The Committee also did not hear from a comparable number of patients and advocates who asked to present their perspective on why the continued exclusion is discriminatory, possibly unconstitutional, and contrary to the established principles in *Carter v. Canada*.

The absence of comprehensive, peer-reviewed empirical evidence to support many of the claims made by the witnesses present a challenge to the credibility of the Report's recommendations that "evidentiary and systemic conditions necessary for safe and equitable implementation cannot presently be met." Much of the testimony heard at Committee relied on clinical and non-clinical opinions, anecdotal experience, and theoretical risk projections rather than on findings drawn from rigorous peer-reviewed scientific evidence. While concerns about diagnostic uncertainty and irremediability were frequently raised, witnesses rarely presented empirical evidence to substantiate the arguments they put forward. The Committee has also made little effort to distinguish between evidence-based conclusions and opinion, whether it be based on professional or personal experience. The result was a body of testimony that, however sincere, did not meet the evidentiary standard one would expect to underpin a parliamentary recommendation on a matter of such social, legal, and medical consequence.

Where empirical evidence was presented and referenced at Committee, it was often selectively presented or insufficiently interrogated. Witnesses opposing extension cited studies suggesting elevated suicide risk and diagnostic instability in populations with serious mental illness; the Committee did not systematically examine whether those studies addressed the specific population that the Committee was mandated to examine. This left the Committee without a comparative evidentiary foundation that is standard practice in previous Joint Parliamentary Committee legislative reviews.

This imbalance in the Committee's process weakens the credibility of the recommendations, particularly among persons on whom these recommendations will have the most significant impact.

For these reasons, the dissenting members cannot accept that the Committee's conclusions constitute a sound evidentiary basis for policy and therefore ask the Government of Canada to refer this matter to the Supreme Court of Canada.

SUPPLEMENTARY OPINION MP MARCUS POWLOWSKI

According to Albert Camus the most fundamental question facing all of us is whether life is worth living- or whether we should end it. This is however not the question we are addressing in determining whether we allow MAiD where mental illness is the sole underlying medical condition (hereinafter MAiD for mental illness). We are being asked whether the state ought to, or perhaps more precisely whether the state is obliged to assist, an individual who make such a choice. More starkly the question is whether the state is obliged to actively help complete the choice- to take a life.

Let us be clear suicide is not illegal, nor is attempting suicide. It is however illegal to assist someone end their life or attempt to end their life. It is also illegal to end someone's life even though they consent. The criminal code however exempts doctors from this provision if they carry out MAiD in accordance with certain conditions enumerated in the criminal code.

The Charter Issue

Unfortunately, the discourse about whether to allow MAiD for mental illness seems to have been largely reduced to the somewhat simplistic question of whether not allowing it is a violation of the Charter. The argument being if we allow MAiD for physical illness, but do not allow it for those with mental illness, we discriminate against those with mental illness (under s.15) and inappropriately restrict their liberty or threaten their security (s.7). From that perspective the key question then ultimately is whether or not allowing MAiD in this context can be justified as proportionate and constitutes a "reasonable limitation" under s.1. Perhaps, as many witnesses in the study suggested, the question of whether to allow MAiD for mental illness will ultimately be decided by the Supreme Court. If a S.1 analysis is the extent of the SCC's consideration, I think it would be deeply disturbing for reasons that will follow. However, I would first like to address the question of the s.1 analysis.

I think the courts ought to conclude, as did our committee, that not allowing MAiD for mental illness, until such time as some fundamental concerns are addressed, is a reasonable limitation under s.1. These fundamental concerns are the difficulty/perhaps even impossibility of determining irremediability of mental suffering (a core requirement under the law), and the lack of ability to distinguish suicidality from rational decision making in someone with a mental illness (I will return to this issue, and explain why it is so important, at the end of this submission). Numerous witnesses cited these concerns as reasons why we should decline to expand MAiD to this population.

There is also the difficulty in being assured that anyone in this country can really be said, through the long course of their suffering (as is presumably needed to warrant receiving MAiD), to have had access to the mental services and social supports which may have alleviated their suffering. As our committee heard, over and over again, many Canadians lack access to primary mental health services particularly in rural areas and in under-served communities such as indigenous communities. Furthermore, in many parts of the country those with mental illness

face significant delays (i.e. years) in accessing higher levels of psychiatric interventions such as ACT teams (see Dr Maher's testimony).

In addition, although some, perhaps a majority, of MAiD providers assured us of their readiness to provide MAiD for mental illness, and the adequacy of existing safeguards, we also heard disturbing stories of questionable conduct by some MAiD providers. Given what we heard it is hard not to conclude that some providers take an exceedingly expansive interpretation of what constitutes "serious and incurable illness, disease or disability", what constitutes an "advanced state of irreversible decline in capability"; and what constitutes "enduring physical or psychological suffering that is intolerable". Furthermore, we heard stories of doctors with a seemingly cavalier attitude towards ending a life.

Although we were assured that mechanisms, such as Colleges of Physicians and Surgeons, would provide adequate safeguards, we were presented with scant, if any, evidence to indicate that such bodies have, as of yet, seriously pursued allegations of misconduct by MAiD providers. This does not mean that colleges have not received complaints or looked into them. As the president of the Nova Scotia College of Physicians and Surgeons pointed out- colleges only publish the reports of hearings when there has been a finding of wrong doing. That being said the paucity of any prosecutions of providers, combined with the suggestion by a number of witnesses that in fact there seems to be a lacunae of law enforcement when it came to MAiD ought to give rise to concern. Several witnesses suggested the criminal system, the medical colleges, and at times government Ministry's responsible for MAiD provision (BC), all allegedly treat enforcement as someone else's responsibility. Given the lack of evidence to the contrary it is frankly difficult to believe that the system is ready to expand.

Of course, the government in arguing that whether a limitation is justified comes down to an Oakes test. Although I will not attempt such an argument, I would suggest the Oakes test often comes down to a question of "least drastic means". Could the government not craft a system that would address the enumerated concerns but allow for genuine cases of irremediable illness and therefor allow patients with solely mental illness the same services as those with physical illness? I would suggest that the answer to this is perhaps- at some point in the future. Mental health access could be improved, and practitioners could come to some agreement on how to distinguish suicidality from a rational decision to end someone's mental suffering. However, the latter seems to be a long way away- given the testimony we received from many top psychiatrists.

But perhaps we will never be ready for MAiD for mental illness as the law is currently written. Numerous very experienced psychiatrists told us of seemingly irremediable cases where for some reason patients, after prolonged periods of seemingly irremediable suffering, the person eventually got better and started to enjoy life again. Furthermore, what evidence there is seems to suggest psychiatrists can not accurately predict who will not get better.

Perhaps the simplest solution to the legal question is to recognize the requirement of irremediability as being dispositive of the issue. The law as written requires irremediability. If

there is really no way to accurately determine irremediability it would seem we would need to change the law if we want to allow for MAiD for mental illness.

We did, I would acknowledge, hear the argument that perhaps with some physical illness irremediability is not certain either (the argument was most forcibly made by Professor Downie- a law professor not a medical clinician). To the extent that there are such cases I would suggest it would be more appropriate to question whether MAiD is appropriate in any such case where there is uncertainty over the medical prognosis- rather than to accept the conclusion of those practitioners who suggested they were "comfortable" with making a decision about irremediability even if there was inherently some inability to come to that conclusion with reasonable certainty.

I would suggest the elected legislature is totally justified in drawing a line, in deciding that we are unwilling to support the state enabling physicians to taking the life of someone who, perhaps, would have gotten better. The decision of whether we do so is a moral decision and very much a reflection of what we value as a society. As such it is a decision more appropriately made by those of us who are elected by the members of society, and who are ultimately accountable to the people- at the poll box, rather than the unelected courts.

When is the State justified in taking a life?

To reduce the question of whether to allow MAiD for mental illness to a simple Charter based consideration of whether people with mental illness are due the same "benefit" (access to MAiD) as those with physical illness is wrong.

The prohibition on taking a life is I would suggest the very basis on which society is built- the maxim "live and let live" is both trivial and at the core of all human interactions. To take a life is a decision that is far more profound than any other decision. It is irreversible. Furthermore, to take someone's life has for a very, very, long time been considered the worst sin, the worst crime.

Furthermore such sentiment would seem to span almost every culture and every religion. "Thou shall not kill" is of course the first of the ten commandments. The sanctity of life is at the heart of- Islam, Hinduism, and Buddhism and perhaps all religions. Nor does one have to believe in any religion to believe in the sanctity of life- it is of course the very core of secular humanism. It remains a core constitutional principle. A state that starts tinkering with the concept of killing being wrong, to rationalize it as "sometimes justified", is on a very dark path.

We have rightly decided that when someone is dying, and their suffering is intolerable, they should be allowed MAiD. Allowing this is a reasonable choice as a compassionate nation. There also may be instances where death is not reasonably foreseeable, but an individual's pain is clearly irremediable and intolerable and perhaps MAiD is a warranted intervention (I will not wade into the Track 2 debate). We ought however to be exceedingly cautious in expanding access to MAiD beyond this.

Many, many, people throughout the world live in misery- indeed it is at the core of the human experience. Undoubtedly at times the misery is, at least in part, due to mental or physical pain. But one's degree of unhappiness in life is also largely, sometimes overwhelmingly, determined by one's social circumstances- whether you have people who care about you, whether you are loved, whether you have adequate housing, food, or a fulfilling job. And perhaps more than anything whether you can believe you will ever have access to any of these things, and whether you feel you and your life are valued. We heard this from many learned witnesses. More importantly we all know this from our personal experience.

I do not think we as a society should ever accept killing someone in order to alleviate a burden of suffering imposed, at least in part, by controllable societal factors. Factors like the availability of housing, social support, access to mental health services- factors that to some extent are under the control of- the government. A government offering death as an alternative to addressing these issues is not a humane and compassionate government- it is the opposite.

Why do we try to prevent suicide?

We heard repeatedly in testimony about the concern as to whether we can distinguish suicidality from a rational decision, by someone with a mental illness, to end their suffering. The unstated implication being we do not want to facilitate suicide. Indeed the state has historically, and uncategorically, attempted to prevent people from killing themselves- however that position can and perhaps ought to be challenged.

One of the ways society actively tries to prevent suicide is to give doctors the power, and duty, to institutionalize someone if they are suicidal (called a Form 1 in Ontario). Once when working as an emergency room doctor and filling out a Form 1 I was confronted by a mature, and seemingly very rational patient, who asked "what right I [had] to decide what [he] did with [his] body". I responded with what I believe is still the right answer- which is this- there are two reasons why society ought to have the power. First to protect an individual from themselves. When in the depths of depression, you can not see, or believe, that you will get better. This is the nature of depression. It is also why people become so despondent and want to die. The vast, vast, majority of people do, however, get better. Tincture of time heels many things. There are countless people around the world who will attest to this fact and are thankful they were not successful in ending their lives. We heard some such stories in testimony.

The second valid reason the doctor, on behalf of the state, having the right to intervene to prevent suicide is to protect the suicidal person's family and loved ones. A person who ends their life by suicide is dead. Their suffering is over- however the family members and loved ones may well live the remainder of their lives profoundly affected by the loss, and haunted by the belief that it came about because of something they did, or did not, do. The profound harm to loved ones, that comes from suicide, is something which often seems ignored in our individual right's based drive to maximize personal autonomy. If you talk to people who are suffering to

the extent they want to die, as I often did as an ER doctor, you will often find the loss of a loved one, or multiple loved ones, as a key driver. I would suggest society has a duty to try to protect family members from such psychological harm.

I would suggest these two things- protecting someone from themselves because- most people do get better, and the protection of family and loved ones- are at the heart of why we as a society try to prevent suicide. It is also why the question of suicidality versus a reasonable decision of a person with mental health problems to end their life, is such an important question. Although I chose not to address this issue as part of a s.1 analysis, I would suggest that the state's well founded concern with preventing suicide is an important part of why prohibiting MAiD for mental illness is a reasonable limitation under s.1.

It can be argued that allowing MAiD for mental illness, thereby legitimizing death as a therapeutic option for mental suffering- totally undermines the work of those who spend their professional lives fighting mental suffering (psychiatrists, psychologists, nurses). More profoundly it sends a message that undermines the efforts of countless people around the world who spend their lives battling their own mental illness or trying to help a loved one (family member or friend, loved one) feel that life is worth living. Mental suffering is seldom something that is born alone.

Allowing MAiD for mental illness may have other ramifications. The committee heard of the suicidality contagion being a valid concern. This is the idea that when one suffering person kills themselves another one who is suffering is more likely to do so. This is a particular concern in some communities (like indigenous communities) where suicide rates, especially amongst the young, are high. What message does allowing MAiD for mental illness send to others who are suffering? Surely it sends a message- death, including suicide, is a rational option. There is some evidence to suggest that this is not just a theoretical concern. Several expert witnesses cited studies showing that suicide rates had gone up in jurisdictions (most notably the Netherlands) after they introduced MAiD for mental illness. they also cautioned about the impact of public reporting on this, and—as sometimes in the case of MAiD —overly positive presentations of it; and that this directly and dramatically impacts on young people

Albert Camus may be right in saying that the most fundamental question facing all of us is whether to continue living. The decision is central to our being human, to controlling our own destiny, to our autonomy. The option to end one's life remains, irrespective of MAiD, readily available in Canada. Furthermore, there are painless options readily available. One example being illicit narcotics like fentanyl. To my dismay it is arguably easier for my teenage sons to access fentanyl in my hometown of Thunder Bay than it is for me (a doctor) to renew my Lipitor prescription (a cholesterol medication).

In recommending that we not extend MAiD to those with mental illness we are not suggesting embarking on a new path of prohibiting suicide, or further trying to limit people's autonomy. We are suggesting the state decline to provide assistance to people with mental illness ending their lives and decline to allow medical professionals to actively do it for them.

Thanks

We have heard the heart felt testimony of those who bare the pain of having lost someone they loved, and thought was going through transient depression, to a seemingly over zealous MAiD providers. We hear you. We also heard perhaps indirectly from those seeking MAiD for mental illness. We hear your pain we hear your request. We are sympathetic to your suffering. It may seem facile but I do hope you find your path in life. During our study we heard from many compassionate psychiatrists who refuse to give up on their patients who say they will always be for them even in their darkest moments when there appears to be no hope. I trust you have such help and that both they, and society, do not give up on you, or stop trying to help.

Lastly, I would like to thank everyone else, on all sides of this debate- for their valuable contributions to our study. I would also like to thank all of the members of the committee, the clerks and analysts for all of their work. The clerks and analysts are people who do most of the work and get the least of the credit.

Conclusion

We need to pause MAiD for mental illness indefinitely. Perhaps at some point in the future, should some of the issues, that have been discussed here, be successfully resolved- the issue could be re-examined.

Doing so does not mean the state does not hear from those who are suffering or has nothing to offer. Mental health services have to be made better, more accessible. Furthermore, the government certainly has a central role in addressing the socioeconomic factors that often are at the heart of people's unhappiness. This is where the government needs to direct its efforts and its resources.

The Government Must Support Bill C-218 and Permanently Exclude Mental Illness as a Sole Underlying Condition for MAID

Special Joint Committee on Medical Assistance in Dying: Conservative Supplementary Opinion

This Supplementary Report reflects the views of the Conservatives who serve on the Special Joint Committee on Medical Assistance in Dying (the “Committee”): The Honourable Yonah Martin (Co-Chair, Senator, British Columbia), Tamara Jansen, M.P. (Co-Vice-Chair, Cloverdale—Langley City), Michael Cooper M.P. (St. Albert—Sturgeon River), Andrew Lawton M.P. (Elgin—St. Thomas—London South), and Todd Doherty M.P. (Cariboo—Prince George).

Introduction

Conservatives support the Committee’s recommendation that the scheduled expansion of MAID in cases where a mental illness is the sole underlying medical condition (MAID MI-SUMC) be indefinitely paused.

In 2021, Conservatives voted against the Senate amendment to Bill C-7 which established a sunset clause for the coming into force of changes to the *Criminal Code* that would allow MAID MI-SUMC. Each time this issue has been considered in the recent parliaments, Conservatives have opposed this expansion.

The Liberal government has been forced to delay the expiry of the sunset clause two times by introducing emergency, last-minute legislation following recommendations from previous iterations of this committee. While Conservatives of course supported these delays, it was always the Conservative position that this proposed expansion should be abandoned permanently. It is not possible to safely implement MAID MI-SUMC, as the evidence before the Committee has clearly demonstrated.

We are pleased that the Committee has finally aligned itself with Conservative leadership on this issue, listened to the evidence, and recommended an indefinite pause to expansion. We strongly encourage the Liberal government to accept this recommendation.

The purpose of this supplementary report is as follows:

1. To encourage the government and Parliament to adopt Bill C-218, a Conservative Private Member’s Bill that will achieve the legislative objective of the Committee’s recommendation and has already begun the legislative process;
2. To put on the record additional recommendations related to MAID MI-SUMC and the current MAID regime in Canada; and
3. To offer additional observations and considerations related to MAID MI-SUMC and the current MAID regime in Canada.

Finally, Conservatives acknowledge, as was highlighted in the Committee’s main report, that there is some debate about whether the term “mental illness” or “mental disorder” is the appropriate term to use in the context of MAID MI-SUMC. The *Criminal Code* currently uses the term “mental

illness”, though that term is not formally defined in the legislation. Conservatives are satisfied with the use of the term “mental illness” and encourage the government to establish a formal definition.

The Key Concerns with MAID MI-SUMC

As Conservatives have highlighted over the course of debates on the issue of MAID MI-SUMC since 2021, there are two key problems with MAID MI-SUMC. First, it is difficult, if not impossible, for a MAID assessor to determine with certainty that a mental illness is irremediable.¹ Second, it is difficult for a clinician to distinguish between a “rational” request for MAID MI-SUMC, and one motivated by suicidal ideation.²

Part of the impetus for the last two emergency extensions of the sunset clause was to provide the government with time to undertake to resolve these two key concerns surrounding MAID MI-SUMC. Based on the evidence the Committee heard, it is clear that these key concerns have not been resolved and the idea that these issues even can be resolved is highly questionable.

Irremediability Cannot Be Accurately Determined

The Committee heard from several experts who explained that it is impossible to determine whether an individual case of mental illness is irremediable.³ This is a serious problem should MAID MI-SUMC ever be made available in Canada. Under the current law, in order for a person to be eligible for MAID, it must be determined that their condition is irremediable.⁴

Since irremediability cannot accurately be predicted, MAID MI-SUMC falls outside of the boundaries of Canada’s MAID regime. Further, the human cost associated with terminating the life of a patient who may have gotten better presents an unacceptable risk.

Inability to Reliably Distinguish Suicidality from a MAID Request

The Committee heard ample evidence that clinicians cannot reliably distinguish suicidality from a request for MAID when a mental disorder is the sole underlying condition.⁵ It is important to note that suicidal ideation is a symptom of many mental illnesses.⁶ Witnesses have testified in previous iterations of this committee that 90% of those who commit suicide have a diagnosable mental illness.⁷ Conservatives have always believed that state-facilitated suicide cannot be the antidote to suicidal thoughts.

So long as it remains difficult to distinguish between suicidality and a “rational” request for MAID, MAID MI-SUMC will blur the line between suicide prevention and suicide assistance. MAID MI-

¹Conservative Supplemental Opinion, AMAD, MAID and Mental Disorders: The Road Ahead, January 2024; Evidence: Mar. 24, 2026 (Dr. K. Sonu Gaiind).

²Conservative Supplemental Opinion, AMAD, MAID and Mental Disorders: The Road Ahead, January 2024; Evidence: Apr. 27, 2026 (Dr. Allison Crawford; Dr. Jitender Sareen).

³Evidence: Mar. 24, 2026 (Dr. K. Sonu Gaiind); Apr. 28, 2026 (Dr. Sanjeev Sockalingam); Apr. 27, 2026 (Dr. Jitender Sareen).

⁴Criminal Code, R.S.C. 1985, c. C-46, s. 241.2(1)-(2).

⁵Evidence: Apr. 27, 2026 (Dr. Allison Crawford; Dr. Jitender Sareen); Apr. 28, 2026 (Dr. Sanjeev Sockalingam; Professor Brian Mishara).

⁶Evidence: Apr. 27, 2026 (Dr. Allison Crawford); Sephora Tang brief, 2026, pp. 1-4.

⁷Conservative Supplemental Opinion, AMAD, MAID and Mental Disorders: The Road Ahead, January 2024, p. 44.

SUMC would create clinical and ethical challenges that our health systems in Canada are simply unable to contend with.

In addressing this concern, the government's Expert Panel on MAiD and Mental Illness had this to say:

“In allowing MAiD in [MI-SUMC] cases, society is making an ethical choice to enable certain people to receive MAiD on a case-by-case basis regardless of whether MAiD and suicide are considered to be distinct or not.”⁸

The Committee's recommendation in its main report reflects the fact that Canadian society is not prepared to make this “ethical choice”. Canadians do not wish to see suicide made easier or facilitated by the state as a solution to psychological suffering.

MAiD MI-SUMC Undermines Suicide Prevention Efforts

The Committee heard significant concern that expanding MAiD MI-SUMC would undermine Canada's longstanding commitment to suicide prevention.⁹

For decades, public policy has been built around the principle that individuals expressing a desire to die should be offered intervention, treatment, support, and hope. Witnesses testified that psychiatric MAiD creates a competing message by allowing death to be treated as an acceptable response to suffering that arises from a mental illness.¹⁰

The Committee heard evidence that many individuals contacting crisis services already raise MAiD alongside suicidal thoughts and that the overlap between the two is substantial.¹¹ Witnesses warned that authorizing MAiD in this context risks creating confusion about whether society views certain lives as worthy of continued protection and recovery efforts.¹²

Therefore, Conservatives believe that it would be irresponsible for Parliament to authorize MAiD MI-SUMC, and that doing so would undermine suicide prevention efforts.

There Is No Professional Consensus

The Committee heard conflicting testimony regarding whether Canada's medical and psychiatric communities are prepared for the implementation of MAiD MI-SUMC.

While some witnesses argued that appropriate safeguards, standards, and training are now in place, most witnesses strongly disagreed. The Committee heard that significant divisions remain

⁸Health Canada, Final Report of the Expert Panel on MAiD and Mental Illness, p. 66.

⁹Evidence: Apr. 28, 2026 (Professor Brian Mishara; Dr. Roderick McCormick); Apr. 21, 2026 (Dr. John Maher); May 5, 2026 (Dr. Jim van Os).

¹⁰Evidence: Apr. 28, 2026 (Professor Brian Mishara); Apr. 21, 2026 (Dr. John Maher); May 5, 2026 (Dr. Jim van Os).

¹¹Evidence: Apr. 27, 2026 (Dr. Allison Crawford).

¹²Evidence: Apr. 28, 2026 (Professor Brian Mishara; Dr. Roderick McCormick).

among psychiatrists and mental health professionals regarding irremediability, suicidality, safeguards, and readiness.¹³

Several witnesses challenged the claim that a broad professional consensus exists.¹⁴ Some warned that readiness claims rest on constructed consensus rather than shared evidence¹⁵, while others cautioned from international experience that a small group of activist physicians and organizations can normalize psychiatric euthanasia over time.¹⁶ The Committee also heard evidence suggesting that many psychiatrists remain uncomfortable with, or opposed to, the expansion.¹⁷

Having regard for the widespread opposition and concern regarding MAID MI-SUMC among experts and clinicians and given that there is no professional consensus on whether expansion is appropriate, Conservatives believe it would be irresponsible for Parliament to authorize MAID MI-SUMC.

Expansion is Not a Constitutional Requirement

The Committee heard persuasive evidence that Parliament is not constitutionally required to expand MAID MI-SUMC.¹⁸

Witnesses testified that neither the Supreme Court of Canada's decision in *Carter* nor subsequent court decisions concerning MAID established a Charter right to MAID MI-SUMC. The Committee heard that each court decision related to MAID dealt with the unique facts of each case before the court. The courts have never ruled that MAID MI-SUMC is constitutionally required.¹⁹

Witnesses further noted that Parliament retains broad authority to establish safeguards and eligibility criteria for MAID where there is a legitimate objective to protect vulnerable persons from wrongful death. It was argued that maintaining an exclusion for mental illness would be consistent with that objective.²⁰

Conservatives therefore reject the claim that Parliament has no choice but to proceed with expansion. This expansion was a policy decision made by legislators and it can, and should, be reversed by legislators.

There is No System Readiness for MAID MI-SUMC

In addition to undertaking to resolve the challenges around determining irremediability and distinguishing a MAID MI-SUMC request from suicidality, the purpose of the extension of the sunset clause was to give the provinces and territories time to develop system readiness to

¹³Evidence: Apr. 14, 2026 (Dr. Karin Neufeld; Dr. Ramona Coelho); Apr. 27, 2026 (Dr. Allison Crawford); Sephora Tang brief, 2026, pp. 1-4.

¹⁴Evidence: Apr. 14, 2026 (Dr. Karin Neufeld; Dr. Ramona Coelho); Sephora Tang brief, 2026, pp. 1-4.

¹⁵Evidence: Mar. 24, 2026 (Dr. K. Sonu Gaiind).

¹⁶Evidence: May 5, 2026 (Dr. Jim van Os).

¹⁷Sephora Tang brief, 2026, pp. 1-4.

¹⁸Evidence: Apr. 21, 2026 (Professor Kerri Froc); Mar. 24, 2026 (Professor Trudo Lemmens).

¹⁹Evidence: Apr. 21, 2026 (Professor Kerri Froc); Mar. 24, 2026 (Professor Trudo Lemmens).

²⁰Evidence: Apr. 21, 2026 (Professor Kerri Froc); Mar. 24, 2026 (Professor Trudo Lemmens); David Shannon brief, Mar. 2026, pp. 1-4.

implement MAID MI-SUMC.²¹ It is clear from the evidence that the Committee heard that little progress has been made toward readiness. Put simply, the provinces and territories are not prepared to expand MAID MI-SUMC.²²

In addition to this lack of readiness, witnesses also noted that there are already concerns related to effectiveness and enforceability of the existing safeguards under the current MAID regime.²³

Existing Gaps with Safeguards and Oversight

The Committee heard that serious weaknesses remain in Canada's existing MAID oversight framework and enforcement of MAID safeguards.

Ontario MAID Death Review Committee materials were raised as evidence that the current regime is already encountering troubling cases involving mental illness, vulnerability, inadequate supports, and limited accountability.²⁴

Professor Lemmens warned that the reports include cases showing people with very serious mental illness being "fast-tracked to death in Canada,"²⁵ while Dr. Coelho testified that fewer than half of the people in the Ontario coroner reports received mental health or disability supports before death and fewer than 10% received community solutions or income supports.²⁶

Dr. Coelho warned that MAID can allow structural and coercive influences to push people toward death,²⁷ while Professor Lemmens highlighted a case involving mental illness, prior suicidality, and ongoing substance misuse where substance use was not explored, addiction treatment was not offered, and family concerns were not documented.²⁸

The Committee also heard broader evidence that accountability mechanisms are fragmented and often retrospective.²⁹ Health Canada acknowledged that oversight is a patchwork that the federal government does not lead.³⁰ MAID safeguards should prevent mistakes before death occurs; a system that primarily reviews decisions after a MAID death cannot fully address the risk of irreversible error.

Inadequate Practice Standards and Training Resources

The Committee heard claims that practice standards, guidance documents, and assessor training demonstrate readiness, but the strongest evidence pointed the other way.

²¹Bill C-39, An Act to amend An Act to amend the Criminal Code (medical assistance in dying), 44th Parliament, 1st Session; Bill C-62, An Act to amend An Act to amend the Criminal Code (medical assistance in dying), No. 2, 44th Parliament, 1st Session; Conservative Supplemental Opinion, AMAD, MAiD and Mental Disorders: The Road Ahead, January 2024.

²²Evidence: Apr. 14, 2026 (Sarah Lawley, Health Canada); Apr. 28, 2026 (Dr. Sanjeev Sockalingam); Apr. 27, 2026 (Melissa Prokopy; Dr. Kevin Young, OHA).

²³Evidence: Apr. 14, 2026 (Sarah Lawley, Health Canada); Mar. 24, 2026 (Professor Trudo Lemmens); Apr. 21, 2026 (Dr. Christopher Lyon).

²⁴Evidence: Mar. 24, 2026 (Professor Trudo Lemmens); Apr. 14, 2026 (Dr. Ramona Coelho).

²⁵Evidence: Mar. 24, 2026 (Professor Trudo Lemmens).

²⁶Evidence: Apr. 14, 2026 (Dr. Ramona Coelho).

²⁷Evidence: Apr. 14, 2026 (Dr. Ramona Coelho).

²⁸Evidence: Mar. 24, 2026 (Professor Trudo Lemmens).

²⁹Evidence: Apr. 21, 2026 (Dr. Christopher Lyon); May 5, 2026 (Alicia Duncan; Alexander Schadenberg).

³⁰Evidence: Apr. 14, 2026 (Sarah Lawley, Health Canada).

The Canadian Psychiatric Association guidance was criticized as process-oriented and aspirational because it lacks evidence-based criteria for predicting the trajectory of mental illness, does not provide concrete methods for distinguishing suicidality from a MAID request,³¹ and does not reflect a broad consensus within psychiatry.³²

The same concern applies to federally funded CAMAP training. The Committee heard that the curriculum ultimately trains assessors to verify capacity and consent, but not to look further into whether a person's despair may be driven by lack of validation, support, equality, or other circumstances that should trigger protection rather than provision.³³

Guidance and training can help standardize a process, but they cannot resolve the two core problems that have remained unresolved from the beginning: determining irremediability and distinguishing suicidality from a MAID request. A training module cannot create clinical certainty where the evidence says none exists, and it cannot substitute for safeguards capable of protecting vulnerable people before an irreversible death occurs.

Provincial and Territorial Health Systems are Not Ready

The Committee heard evidence that Canada's health-care systems remain unprepared for the implementation of MAID MI-SUMC.³⁴

Witnesses highlighted significant disparities in access to psychiatric care, counselling, addiction treatment, community supports, housing assistance, and culturally appropriate services.³⁵ Many Canadians continue to face lengthy wait times and substantial barriers to accessing treatment that could alleviate suffering and improve quality of life.³⁶

Hospital representatives and mental health experts warned that introducing MAID MI-SUMC in this environment risks creating a pathway to death that is more accessible than the services intended to support recovery.³⁷ Witnesses also pointed to differing approaches among provinces and territories as evidence that readiness has not been established across Canada.³⁸

Concerns Related to “Doctor Shopping”

The Committee also heard evidence that weak oversight can create a risk of “doctor shopping” or “jurisdiction shopping”. The Committee heard of instances where a person whose request was

³¹Evidence: Apr. 28, 2026 (Dr. Sanjeev Sockalingam); Apr. 27, 2026 (Dr. Allison Crawford).

³²Evidence: Apr. 14, 2026 (Dr. Karin Neufeld).

³³Evidence: Apr. 21, 2026 (Catherine Frazee).

³⁴Evidence: Apr. 14, 2026 (Sarah Lawley, Health Canada; Dr. Karin Neufeld); Apr. 27, 2026 (Melissa Prokopy; Dr. Kevin Young, OHA); Apr. 28, 2026 (Dr. Sanjeev Sockalingam).

³⁵Evidence: Apr. 27, 2026 (Dr. Margaret McKinnon; Dr. Sandip Singh Gandham); Apr. 28, 2026 (Neil Belanger; Dr. Roderick McCormick).

³⁶Evidence: Apr. 28, 2026 (Dr. Sanjeev Sockalingam); Apr. 27, 2026 (Melissa Prokopy; Dr. Kevin Young, OHA).

³⁷Evidence: Apr. 28, 2026 (Dr. Sanjeev Sockalingam); Apr. 27, 2026 (Melissa Prokopy; Dr. Kevin Young, OHA).

³⁸Evidence: Apr. 14, 2026 (Sarah Lawley, Health Canada).

denied sought another assessor, sometimes in another jurisdiction.³⁹ In some of these cases, concerns raised by prior assessments were not considered by later assessors.⁴⁰

Taken together, it is clear that Canada is not in a position to expand access to MAID MI-SUMC. There are already concerns related to the enforcement of the current MAID safeguards. Conservatives believe that it is imperative that the government initiate a review of the effectiveness and enforceability of the current MAID safeguards.

The Liberal Government Must Support Bill C-218

Time is of the essence to make changes to the *Criminal Code* to indefinitely exclude those whose sole condition is a mental illness from accessing MAID, as the Committee recommended. If no legislative changes are made, MAID MI-SUMC will become available to vulnerable Canadians on March 17, 2027.

Thankfully, Conservatives have already put forward a legislative solution. Conservative Private Member's Bill C-218 achieves the legislative objective set out by the Committee's recommendation. Notably, C-218 has already begun moving through the legislative process and may be referred to committee for study as early as September.

Some members of Parliament have expressed concern with the bill's use of the term "mental disorder" and would prefer that the bill use the term "mental illness". Conservatives acknowledge the ambiguity between these terms. Conservatives note, however, that the reason that the bill uses the term "mental disorder", and indeed the reason previous iterations of this committee used that term, is due to advice from Dr. Mona Gupta, a member of the Liberal government's own Expert Panel on MAID and Mental Illness.⁴¹ So, there is a sense in which this ambiguity is the government's own making.

Conservatives have no issue with allowing Bill C-218 to be amended at committee stage to use the term "mental illness". In fact, we encourage the government and Parliament to establish a formal definition of "mental illness" in the *Criminal Code*, and we are prepared to work collaboratively with the government to that end.

Support for a bill at second reading stage means that the House of Commons supports the principle of the bill. It would be unfortunate for the Liberal government to oppose a bill that achieves the legislative objectives set out by the Committee's recommendation due to a technicality that can easily be fixed at committee stage. To do so would be nothing more than a display of cynical politics.

Further, it would be a shameful display of cynical politics if the government defeated Bill C-218, only to introduce government legislation related to MAID that does not simply stop the expansion of MAID MI-SUMC but coupled that policy objective with changes to the MAID regime that some members of the Official Opposition may have difficulty supporting.

³⁹Evidence: Apr. 21, 2026 (Dr. John Maher); May 5, 2026 (Alexander Schadenberg).

⁴⁰Evidence: Apr. 14, 2026 (Sarah Lawley, Health Canada); Apr. 21, 2026 (Dr. Christopher Lyon).

⁴¹Health Canada, Final Report of the Expert Panel on MAID and Mental Illness, May 2022; AMAD, Medical Assistance in Dying and Mental Disorder as the Sole Underlying Condition: An Interim Report, June 2022, p. 2.

Supporting Bill C-218 is the most appropriate way for Parliament to stop the scheduled expansion. Conservatives encourage the Liberal government to put politics aside and support this bill expeditiously.

Conclusion

The evidence is clear, as it always has been, that moving forward with expanding access to MAID MI-SUMC is reckless and dangerous. It is clear that the two key concerns – determining irremediability and distinguishing MAID MI-SUMC requests from suicidality – remain unresolved. The evidence casts serious doubt that these issues can be resolved.

Further, it is clear that provincial and territorial health systems are not prepared to appropriately provide MAID MI-SUMC. And serious concerns regarding to the effectiveness and enforceability of MAID safeguards remain in the current MAID regime.

Conservatives are pleased that the Committee has recommended an indefinite pause to the expansion of MAID MI-SUMC, as Conservatives have called on the government to do for years.

Conservatives have already provided Parliament with a legislative solution with Bill C-218. We strongly encourage the Liberal government to support C-218, and we are prepared to work collaboratively with the government to that end.

Having regard for the foregoing, Conservatives make the following recommendations:

Conservative Recommendations

Recommendation 1: Support Bill C-218

The Liberal government should support Bill C-218 and permanently repeal the scheduled expansion of MAID MI-SUMC.

Conservatives are prepared to support an amendment for the bill to use the term "mental illness" rather than "mental disorder" and to work collaboratively with the Liberal government to establish a statutory definition of "mental illness".

Recommendation 2: Strengthen MAID monitoring and reporting

The government should strengthen federal MAID monitoring and public reporting by expanding the data collected under the Regulations for the Monitoring of Medical Assistance in Dying.

The data collected should include social and economic circumstances, psychiatric history, suicidality where clinically documented, supports offered and accessed before provision, and prior MAID assessments and outcomes. Public reporting should allow Parliament and Canadians to identify patterns relating to vulnerability, access to supports, and social determinants of health.

Recommendation 3: Safeguards should prevent mistakes before death occurs

The government should work with provinces and territories to establish minimum national standards for MAID oversight to ensure the effectiveness and enforceability of MAID safeguards.

Those standards should include prospective review mechanisms capable of pausing or stopping a provision where serious compliance concerns arise before death, stronger review of prior records and assessments, clear referral pathways for potential *Criminal Code* violations, and greater independence of oversight bodies from MAID delivery systems.

Recommendation 4: MAID should never be suggested to someone in crisis

The government should review and update federally funded MAID guidance and training materials to ensure assessments are standardized, rigorous, and consistently applied across Canada.

Guidance should clearly state that clinicians should not proactively raise or suggest MAID where a person is experiencing a psychiatric crisis, expressing suicidality, living with unmet disability-related or social support needs, or where concerns exist regarding voluntariness, vulnerability, or external pressure.

Toward these ends, Parliament should adopt Conservative Private Member’s Bill C-260 An Act to amend the Criminal Code (medical assistance in dying — protection against coercion).

Recommendation 5: Review the effectiveness and enforceability of current MAID safeguards

The government should undertake a review of the effectiveness and enforceability of current MAID safeguards to prevent vulnerable Canadians from falling through the cracks of a system that is supposed to protect them.

Respectfully submitted,

The Honourable Yonah Martin, Senator, Co-Chair
British Columbia

Tamara Jansen, M.P., Co-Vice-Chair
Cloverdale—Langley City

Michael Cooper M.P.
St. Albert—Sturgeon River

Andrew Lawton M.P.
Elgin—St. Thomas—London South

Todd Doherty M.P.
Cariboo—Prince George

DISSENTING OPINION BY THE BLOC QUÉBÉCOIS
Special Joint Committee on Medical Assistance in Dying- Eligibility of Persons Whose
Sole Underlying Medical Condition is a Mental Illness

Luc Thériault, Member of Parliament for Montcalm and Bloc Québécois spokesperson on medical assistance in dying

1- A 180-DEGREE TURN BY THE GOVERNMENT

1.1 SINCE June 2022, THE COMMITTEE HAS CONSISTENTLY CONSIDERED IT APPROPRIATE TO EXPAND MEDICALLY ASSISTED DEATH TO INCLUDE PATIENTS WITH SEVERE MULTIPLE DISABILITIES. The only two reservations it had concerned (1) the degree of preparedness of clinical settings to ensure safe and appropriate implementation and (2) the very short timeframe leading up to the March 2023 deadline. These reservations are reflected in the conclusion of the June 2022 interim report by the Special Joint Committee (CSM):

Although work is already underway to implement the Expert Panel’s recommendations, concerns remain regarding the efforts still required to ensure that all necessary measures are in place by March 2023, when marketing authorization may be considered for individuals with mental disorders as their sole medical condition. We urge the federal government to work with the provinces, territories, and other stakeholders to ensure that the Expert Panel’s recommendations are implemented in a timely manner.¹

This applies both to the AMAD committee final report of February 2023, following which the government introduced Bill C-39, and in the AMAD committee report submitted after the panel was reconvened to address Recommendation 13 of the main report from January 2024—following which the government introduced Bill C-62—the committee never questioned the validity of extending access to medical assistance in dying (MAID) for individuals with severe and persistent mental illness (MD-SUMC).

Eligibility for medical assistance in dying was provided for in Bill C-7 as of MARCH 2023. Let’s see what the committee says in its February 2023 Final Report in the section on MAID for individuals with severe mental illness (MD-SUMC):

“Although the Committee respects the view of some witnesses that individuals whose sole medical condition cited is a mental disorder should not be eligible for medical assistance in dying, **the Committee believes, on the contrary, that these individuals should be able to obtain medical assistance in dying, provided they meet the eligibility criteria.** The Committee is also aware of the need to ensure that vulnerable individuals do not seek to

¹ MEDICALLY ASSISTED DYING AND MENTAL DISORDER AS THE SOLE MEDICAL CONDITION CITED: INTERIM REPORT, Report of the Special Joint Committee on Medically Assisted Dying, 2022, p. 22

apply for MAID simply because they lack access to adequate social and medical support. **The Committee supports MAID MD-SUMC, but is concerned that there has not been sufficient time to develop the practice standards mentioned by the Expert Panel.** Witnesses have made it clear that these standards are essential to ensuring a thoughtful and consistent approach to the MAID MD-SUMC. The Committee has taken note of the ministers' announcement to postpone eligibility for the MAID MD-SUMC. As mentioned, Bill C-39 proposes to postpone eligibility by one year, until March 2024. The Committee is aware that this delay may prolong the suffering of some individuals. Nevertheless, the Committee remains focused on this issue and wants to ensure that the standards are in place before the MD-SUMC medical license is permitted. For this reason, the Committee makes the following recommendation:

Recommendation 13

That, five months before the effective date of eligibility for medical assistance in dying (MAID) when a mental disorder is the sole medical condition cited, a special joint committee on medical assistance in dying be reestablished by the House of Commons and the Senate to assess the level of preparedness for the safe and appropriate implementation of MAID (in cases of MD-SUMC). Following this assessment, the Special Joint Committee will make its final recommendation to the House of Commons and the Senate.”

1.2 In its latest report (2026), the Special Joint Committee made a 180-degree turn by questioning the validity of this expansion

- **despite** evidence demonstrating the discriminatory nature of such a position. To this end, Jocelyn Downie's brief, “²” dated March 31, 2026, provides this evidence.
- **This is despite** evidence that preparedness is adequate, according to the Canadian Association of MAiD Assessors and Providers (CAMAP), the Canadian Psychiatric Association (CPA), the Quebec Psychiatric Association (AQP), the Ministry of Health, the Ministry of Justice, and the practice standards established by the working committee funded by the Liberal government to define the practice standards and required training for assessors and providers. (For a better understanding, see the training program developed by the Working Group on Standards of Practice, the CAMAP document titled “Assessing Incurability for MAID Applications,” and the CPA's brief, which was not invited to testify despite its requests for hearings).

² Brief submitted to the Special Joint Committee on Medical Assistance in Dying, Jocelyn Downie, March 2026.

2 C-7 AND THE EXPERT PANEL REPORT

When the House of Commons passed Bill C-7, it was to correct the fact that Bill C-14 was unconstitutional and did not comply with the Carter Decision (see the Beaudoin Judgment) by limiting access to medical assistance in dying strictly to circumstances where death was reasonably foreseeable. This vague concept violated sections 7 and 15 of the Charter of Rights and Freedoms, and left in limbo all individuals capable of making a free and informed decision but grappling with a serious and incurable health condition causing them intolerable suffering *without death being imminent*. Consequently, the safeguards under Track Two were introduced. C-7 also introduced a temporary exclusion for mental illness, which was set to be lifted in March 2023.

David Lammetti then tasked a committee of experts with defining the guidelines for the safe and appropriate application of the MD-SUMC medical assistance in dying (MAID) protocol (when a mental disorder is the only medical condition cited)³. Shortly thereafter, he also established a Special Joint AMAD Committee (Senate–House of Commons) to examine all possible scenarios involving medical assistance in dying. This committee examined *“provisions of the Criminal Code concerning medical assistance in dying and their application, including issues relating to mature minors, advance directives, mental illness, the state of palliative care in Canada, and the protection of Canadians with disabilities.”*

The AMAD Committee began hearing witnesses on April 13, 2022. However, it waited until the Expert Panel on Medical Assistance in Dying and Mental Illness published its report on May 13, 2022, to hear testimony regarding mental health conditions. In accordance with its mandate, the **Expert Panel was required to make recommendations on the following issues:**

- Protocols and guidelines for the assessment and provision of ADM to people with mental illness, for use by national, provincial, and territorial professional health organizations and physicians.
- Additional safeguards to be included in federal legislation to support the safe implementation of medical marijuana for people with mental illness.

The Expert Panel reached the following conclusion: **the existing eligibility criteria and safeguards regarding medical marijuana, reinforced by current laws, standards, and practices in related areas of health care, can provide an adequate framework for medical marijuana for people with severe mental illness (SPMI), provided they are interpreted appropriately to take into account the diagnostic specificity of mental disorders.**

³ Final Report of the Expert Panel on Medical Assistance in Dying (MAID) and Mental Illness, May 2022. [Final Report of the Expert Panel on MAID and Mental Illness - Canada.ca](https://www24.intelcom.ca/maid-report)

3 THE AMAD JOINT COMMITTEE FACES STRUCTURAL PROBLEMS THAT RENDER IT INEFFECTIVE

For the AMAD Joint Committee, obtaining an extension of the deadline **without changing** the committee's internal work organization once that extension was granted has only perpetuated the haphazard extension of the work driven by the federal government's haste. It would have been necessary to draw inspiration from the exemplary methodology of the ASSNAT (National Assembly of Quebec) regarding MAID.

The other source of the problem stems from the fact that, unlike the ASSNAT, the Canadian Parliament will never be the scene of a consensual or bipartisan approach to the organization of its work, because the Conservatives are incapable of setting aside their partisanship when it comes to drug approvals. They will stop at nothing to throw a wrench in the works.

As for our recent work, I'll say just one thing: it's undoubtedly the worst exercise I've been part of since the first Joint Special Committee. The dice were loaded from the start. Throwing three reports in the trash and consigning the suffering of people struggling with mental illness to oblivion is troubling. I find it troubling that we are faced with legislators who are prolonging the exclusion of the MAID MD-SUMC despite the fact that it is discriminatory and unconstitutional, yet who lack the courage to refer the matter to the Supreme Court to prevent this burden from being imposed on suffering patients. This stems from ideological rigidity, sad partisanship, and a glaring lack of compassion. **To constantly hear the argument that problems with access to care and structural vulnerabilities supposedly drive patients to seek MAID rather than seek treatment (even though the evidence proves the opposite), without any proposal for a substantial increase in health care funding, is unspeakable.**

4 STRUCTURAL VULNERABILITIES

With regard to structural vulnerabilities, data from Health Canada, the annual reports on medical assistance in dying in Canada, and a scientific study by James Downar and Kirean L. Quinn titled *"Is Structural Marginalization a Determinant of Medical Assistance in Dying in Canada? Interpretations of Observational Data, Social Context, and Regulatory Reports,"* conclude that structural vulnerabilities do not play a significant role in requests for medical assistance in dying:

"This article examined the use of observational data on medical assistance in dying in Canada, how structural marginalization serves as an indicator of vulnerability, and how these factors might shed light on decision-making capacity and the voluntary nature of decisions related to medical assistance in dying. Drawing on population-level data and case studies, the study reveals that recipients of medical assistance in dying are more socioeconomically

advantaged, have better access to services, and experience a better end-of-life care experience compared to the general population, according to all available indicators. (...) they clearly refute the notion that medical assistance in dying is driven by marginalization or inadequate service delivery on a significant scale in Canada. While there may be exceptions, the anecdotal cases cited to support this claim rarely stand up to scrutiny.”⁴

5 NECESSARY APPEAL TO THE SUPREME COURT

With regard to medical assistance in dying (MAID), it was the Supreme Court that compelled the House of Commons as early as 2015 to amend the Criminal Code in order to address the demands of patients who felt their constitutional rights were being violated. **The Bloc Québécois believes that the Carter decision and the Beaudoin ruling justify extending medical assistance in dying to individuals living with a severe and intractable medical condition whose chronic suffering has become intolerable.**

5.1 From Carter to Beaudoin: The Opening of Pathway 2 and Medical Marijuana for Mental Health Conditions with Severe and Persistent Symptoms

The courts (Carter Decision, Beaudoin Judgment) have established that, in substance, an absolute (general) ban on medical assistance in dying (MAID) for individuals with a mental disorder as their sole medical condition (MD-SUMC) would be discriminatory and unjustified.

On what grounds should the State infringe upon or restrict the right to self-determination of a person with a mental disorder, provided that their decision-making capacity is not impaired? On what grounds should chronic suffering that has become intolerable be **considered reasonable, and on what grounds would such discrimination be reasonable?**

6 THE ROLE OF THE STATE

The role of the state is not to presume to know better than a person facing intolerable suffering what is in that person’s best interest (beneficence) in a matter as intimate as their own death. **The role of the state is to ensure the conditions under which that person can exercise a free and informed choice.**

⁴ Is Structural Marginalization a Determining Factor in Medical Assistance in Dying in Canada? Interpretations of Observational Data, Social Context, and Regulatory Reports, James Downar and Kirean L. Quinn, Canadian Journal of MAID, Volume 1, Issue 1, Fall 2025, p. 42.

7 LAW AND CLINICAL ETHICS

Law and clinical ethics recognize the patient's right to self-determination in a biomedical context. **Free and informed consent, informed decision-making, and the exercise of the patient's decision-making capacity—when properly established according to best practices—stand in opposition to medical paternalism**, which still seems all too prevalent in psychiatry. Thus, the bioethical literature explains that, over the years, we have moved from futile medical treatment ('s obsession with a cure) to the recognition of the right to die. **From that point on, curative over-treatment motivated by controlling medical paternalism gave way to the patient's wishes and the patient's right to seek palliative care** (opponents referred to this as "passive euthanasia" and opposed palliative care), **comfort care, and later, medical withdrawal**. Furthermore, this respect for the autonomy and right to self-determination of the suffering patient has led, in clinical practice and the law, to the **recognition of the refusal of life-sustaining treatment and the withdrawal of treatment** as elements of **good medical practice**.

We must ask ourselves: why should it be any different for certain patients struggling with a mental disorder whose suffering has become intolerable, whose condition has been established as chronic over time, and whose medical records demonstrate beyond a shadow of a doubt that all available treatments have been administered without resulting in a permanent improvement or a significant alleviation of the suffering that has become intolerable?

Some people believe that the Carter Decision does not apply to mental disorders because prohibiting the expansion of the right to medical assistance in dying would constitute "reasonable" discrimination, ostensibly to protect patients facing structural vulnerabilities. However, the expert report is clear: just because a person requests it does not mean that a request for medical assistance in dying can be considered and granted. There are strict guidelines.

We must therefore ask: on what grounds, or under what conditions, can suffering be deemed "reasonable"? How can Section 1 of the Charter permit a blanket ban on medical assistance in dying for individuals with severe and persistent mental illness (SPMI)? Some psychiatrists argue that it is impossible to establish the irreversibility of a mental disorder. They question whether psychiatry can even establish a prognosis of incurability, let alone a diagnosis... Yet all these challenges are addressed in the Expert Group's report, which proposes guidelines and precautions to ensure the safe and appropriate application of the MD-SUMC medical authorization. One need only refer to it.

7.1 Reflections on the Importance to Be Given to Anecdotes

One question remains unanswered by these few psychiatrists who, relying on anecdotal evidence and without providing any proof, claim in the same breath that all mental disorders can always be cured and alleviated, and that psychiatry is mistaken not only regarding prognosis but also regarding diagnosis. Why should we rely on anecdotal accounts—lacking supporting evidence—from patients who, according to them, might have met the criteria and precautions outlined in the Expert Group’s report, when these psychiatrists have no experience with the MAID—neither as evaluators nor as providers—and are, in fact, opposed to Pathway 2 or the MAID in general?

On what grounds should a patient—a victim of the stigma often associated with mental disorders, who has suffered for decades and tried every available treatment without lasting success—be forced to suffer indefinitely? For how much longer? What alternative do they have left? Suicide? A hunger strike to move closer to Path 1, or shouldering the burden of challenging the discrimination they face in court?

8 SUBMITTING AN APPLICATION DOES NOT MEAN BEING ELIGIBLE

8.1 The report by the expert panel that proposed the conditions under which the MAID could be extended to MD-SUMC patients is clear. Just because a patient applies does not mean they will be eligible. During her testimony, Stéphanie Green explained that a person is ineligible⁵ :

- Is in a suicidal crisis
- Who has just been admitted and diagnosed
- Whose request is based on structural vulnerabilities
- Who refuses, without justification, all treatments that could improve their condition
- If accessible and effective treatments are available
- If the evaluators cannot determine all or part of the criteria

8.2 Because it is recognized that for mental disorders, irremediability and incurability are not always as easy to establish as they are for Track 1 diseases (although the intensity of suffering may be similar), and that suicidal ideation must be distinguished from a deliberate and consistent desire for assisted medical death, the Collège des médecins du Québec has developed guidelines—five conditions to prevent any misuse⁶ :

- 1) The decision to grant medical assistance in dying in a case of mental disorder must not be made solely within the context of a single episode of care, but must be based on a comprehensive and fair assessment of the patient’s situation.

⁵ AMAD, Testimony from April 27, 2026, Stefanie Green

⁶AMAD, testimony of November 28, 2023, Collège des médecins du Québec

- 2) There must be no suicidal ideation, as in a case of major depressive disorder.
- 3) Intense and ongoing psychological suffering, confirmed by severe symptoms and impaired overall functioning, must be present over a long period and must rob the patient of all hope of relief from the burden of their situation. This prevents them from fulfilling their life goals and causes their existence to lose all meaning.
- 4) There must be a long history of care involving appropriate follow-ups, multiple attempts at available therapies recognized as effective, as well as sustained and proven psychosocial support.
- 5) A multidisciplinary assessment of the requests must have been conducted with the essential participation of the physician or nurse practitioner specializing in mental health who has been responsible for the person's care, as well as a psychiatrist consulted specifically in the context of the request for medical assistance in dying.

Finally, the Collège des Médecins concludes:

“We believe that, if these guidelines are followed, individuals suffering from a serious and irreversible mental health disorder could also benefit from medical assistance in dying. We must prevent individuals who lack access to appropriate care—or who find the services offered unacceptable, such as long-term residential care with no prospect of regaining greater autonomy—from opting, out of desperation, for medical assistance in dying.”

9 THE STATE OF PREPARATION FOR SAFE AND EFFECTIVE IMPLEMENTATION

Evidence of **de facto accessibility** linked to a level of preparedness for the safe and appropriate implementation of the MD-SUMC marketing authorization **was demonstrated in the recent AMAD committee study. Even if Quebec and Alberta do not move forward, it would be unreasonable not to acknowledge this.** Those who oppose the MD-SUMC marketing authorization must be doing so for another reason. As early as 2024, 124 physicians and nurse practitioners from across Canada—including providers and evaluators from Quebec—wrote a letter to the Senate stating that the clinical community was ready.

10 RECOMMENDATIONS FROM THE BLOC QUÉBÉCOIS

10.1 Given that:

- That the relevant government authorities—the Ministry of Health and the Ministry of Justice—affirm that substantial groundwork has been done regarding training and understanding of the MD-SUMC Medical License, and that clinical settings are ready (except for Alberta and Quebec, for which no data has been provided). That this is also the view of the ACP, the AQP, the CAMAP, and certain medical colleges, which have told us that being prepared is a duty;
- That Quebec’s Minister of Health, Ms. Sonia Bélangier, wrote to the AMAD committee stating that, although Quebec has currently chosen to expand the MAID to cover neurodegenerative diseases rather than for the MAID MD-SUMC, the discussion on the subject remains open;
- That the discussion will not continue based on this Committee’s recommendation, which indefinitely shelves the possibility of marketing authorization for MD-SUMC ;
- That a new review of the file would provide the Quebec National Assembly with essential reports that were not available to it during its initial review of the MD-SUMC marketing authorization (notably the federal Expert Panel report);
- That it has been clearly established that submitting an application does not guarantee eligibility, and that several experts have told us that the guidelines set out in the experts’ report are sufficient to protect patients (a person is ineligible if they are in a suicidal crisis, have recently been admitted and diagnosed, their request is based on structural vulnerabilities, they refuse without justification all treatments that could improve their condition—provided such treatments are accessible and effective—and the evaluators are unable to rule on all or part of the criteria;
- We must avoid condemning patients—whose suffering related to their mental disorder has become intolerable, even though they would be eligible for the MAID MD-SUMC—to a life in psychiatric palliative care wards;
- That we must avoid promoting medical paternalism! That depriving a person with a mental disorder whose chronic suffering is intolerable of their right to self-determination and failing to respect their decision-making capacity—once it has been properly established in accordance with best practices—is discriminatory.

- That the committee heard during its hearings that there is a legal dispute regarding the interpretation of the Carter decision on the issue of discrimination in relation to the MAID solely in connection with a mental disorder, but that it is morally unacceptable to place the burden of this legal clarification on patients;

10.2 The Bloc Québécois recommends:

RECOMMENDATION 1: The government must promptly ask the Supreme Court to clarify the interpretation of the Carter decision regarding discrimination in the context of a medical license application (MAID) where a mental disorder is the sole medical issue cited, so as to avoid broadly excluding patients with a mild to moderate psychiatric disorder (MD-SUMC) from the possibility of having their MAID application reviewed.

RECOMMENDATION 2: Pending the Supreme Court’s ruling on this dispute over legal interpretation, the government must extend the sunset clause and, above all, must not prematurely and indefinitely suspend its entry into force.

RECOMMENDATION 3: With regard to MAID for MD-SUMC (medical assistance in dying when a mental disorder is the sole medical condition cited), Recommendation 16 of the Expert Panel’s report—which calls for establishing prospective monitoring at the conclusion of the assessment process—should be implemented as an additional (clinical) safeguard. Since only a very small number of patients would be eligible based on the testimonies collected, this measure would be easy to implement. For example, in Quebec, the End-of-Life Care Commission, which systematically conducts retrospective monitoring, could easily fulfill this clinical requirement and put the necessary systems in place to carry out this task.