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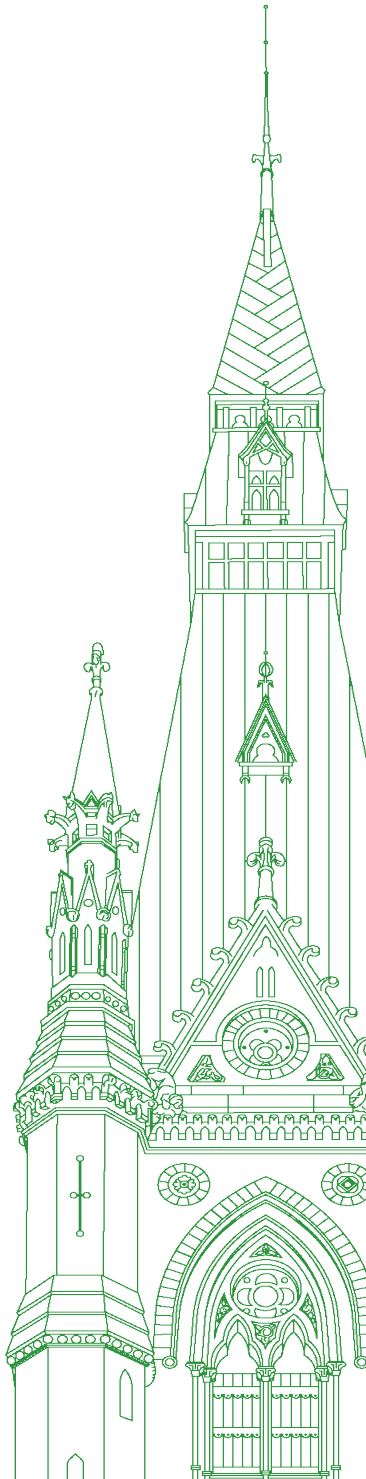

Co-Chairs: Marcus PowlowskiYonah Martin

Special Joint Committee on Medical Assistance in Dying

Monday, April 27, 2026

● (1835)

[*Translation*]

The Joint Vice-Chair (Hon. Pierre Dalphond (Quebec (De Lorimier), ISG)): Good evening.

My name is Pierre Dalphond, and I'm a senator from Quebec. Our esteemed colleague Senator Martin cannot be with us this evening and has asked me to act in her stead in my capacity as joint vice-chair of this committee.

Pursuant to the order of reference adopted by the Senate on February 26, 2026, and the order of reference adopted by the House of Commons on February 13, 2026, the special joint committee is meeting to examine the eligibility of persons whose sole underlying condition is a mental illness to receive medical assistance in dying, or MAID.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. Members are attending in person in the room and remotely using the Zoom application.

On that note, before we get started, I would like to confirm that the sound tests were completed successfully. I would ask all in-person participants to consult the guidelines on the cards on the table. These measures are in place to help prevent audio and feedback incidents that could harm the interpreters.

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

Please wait until I recognize you by name before speaking.

For those participating by video conference, click on the microphone icon to activate your mike, and please mute yourself when you are not speaking.

For those on Zoom, at the bottom of your screen, you can select the appropriate channel for interpretation: floor, English or French. For those in the room, you can use the earpiece and select the desired channel.

A reminder that all comments should be addressed through the chair.

For members in the room, if you wish to speak, please raise your hand. For members on Zoom, please use the raise hand function.

Honourable senators and members, this is meeting number five of the special joint committee, which is charged with carrying out a comprehensive review relating to the eligibility of persons whose sole underlying medical condition is a mental illness to receive MAID.

Before we get started, I want to let you know that it was agreed that our time with each panel would be 15% shorter to account for voting. When the bells ring for a vote in the House of Commons, we will suspend the meeting for 15 to 20 minutes, so members have time to get to the right floor and back.

I would now like to welcome our first panel.

[*English*]

As individuals, we have Dr. Margaret McKinnon, professor, department of psychiatry and behavioural neurosciences, McMaster University, and Dr. Lilian Thorpe, full professor, department of community health and epidemiology and department of psychiatry, University of Saskatchewan. Representing the Canadian Association of MAID Assessors and Providers, we have Dr. Stefanie Green, by video conference, and Dr. Gordon Gubitz, who is with us in the room.

For our witnesses appearing by video conference, should any technical challenge arise, particularly in relation to interpretation, please signal it, and we will work to resolve the issue. Please note that we may need to suspend during these times, as we need to ensure that all members are able to fully participate.

Dr. McKinnon and Dr. Thorpe, I will invite each of you to deliver a brief opening statement of five minutes, followed by a joint statement from Dr. Green and Dr. Gubitz. Following your remarks, our members will ask questions.

Dr. McKinnon, the floor is yours.

Margaret McKinnon (Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University, As an Individual): Thank you.

Good evening. My name is Dr. Margaret McKinnon. I'm a licensed clinical psychologist who serves as a full professor and associate chair of research in the department of psychiatry and behavioural neurosciences at McMaster University. I have secured funding for my work in the field of post-traumatic stress from the Public Health Agency of Canada, National Defence, Veterans Affairs Canada and the Canadian Institutes of Health Research. I'm invited nationally and internationally to serve as an expert surrounding post-traumatic stress injuries.

However, I am not only an expert in the field of mental health and well-being. I am also a person with lived experience and a long-term history of depression, post-traumatic stress disorder and suicidality. As such, I am here this evening as a person with lived experience, and would ask the committee to be respectful of that status in their questioning. This is very difficult testimony to give.

Finally, I am testifying tonight as an individual. I do not represent any organizations in the remarks I will provide.

I would like to emphasize here that while individual experiences are not generalizable, they are in fact illustrative and point to the potential consequences of a decision to adopt MAID for mental health. I have tremendous sympathy for individuals wishing to access MAID and great empathy for those who are suffering. I'm here tonight, however, to represent Canadians who may feel much less safe and who feel at risk with the possibility of this legislation being enacted. This is a perspective that is rarely considered.

My own history with depressive symptoms and a subsequent diagnosis of major depressive disorder now spans nearly 40 years, since I was 12 years of age. I have received continuous treatment for depression since I was 24 years of age, including gold standard therapeutic approaches. In 2001, during my honeymoon, I was aboard an Air Transat plane that ran out of fuel midway over the Atlantic, during which we were prepared for the ditching of the aircraft into the ocean over a 25-minute period. Having survived this incident, I also developed PTSD.

I am very fortunate to be part of the system, and over the years have received access to both standard and leading-edge mental health treatments. Despite this access and the ongoing support of family and very close friends, I suffered a years-long period where I wished to die, had a fully fledged suicide plan and access to means, and lived with a hopelessness that meant I saw my life as not worth living. Critically, I would have been an ideal candidate for MAID for mental health at the time, with a long-term history of mental health difficulties that I saw as both irremediable and associated with grievous suffering, despite continuous treatment.

In fact, if the proposed legislation allowing MAID for mental health conditions had existed at the time, I believe I would not be here to testify tonight. Instead, I believe I would have availed myself of this option at a time when I was also a much-loved family member and friend and functioning at the level of an accomplished faculty member and clinician at a major Canadian university and hospital. I would have chosen this option to die and would not be here. Instead, I am now in a period of primarily sustained recovery, despite my previous persistent wish to die.

In the intervening years, I have experienced periods of both relapse and recovery, with treatment ongoing. A year ago, I found many of these thoughts of suicide and the desire to die returning. Despite being a mental health professional, it was shocking to me how quickly these thoughts returned, how strongly I believed I wanted to access MAID and how irrevocable these feelings felt. While I recognize that I may have needed to wait for MAID access under these conditions, the future I envisioned for myself at that time was one that clearly included MAID.

In sharing this experience, I hope I'm illustrating to the committee the lack of safety that some Canadians feel in light of this legislation. To me, this feels like an option that, should I become ill for a long enough period of time or my life circumstances change substantially enough, I believe I may attempt to access, despite clearly recognizing when well that there is hope for recovery, as I'm experiencing now.

I am very fortunate to be a person with good access to mental health care, financial means and extensive social support, yet I feel at great risk in this situation. Moreover, as has been illustrated repeatedly in this committee's deliberations, it is a fallacy to believe that all Canadians have equal access to treatment for mental health conditions. In the case of PTSD and depression, national and international guidelines recommend what are essentially first-, second- and third-line treatments. As incidents like Tumbler Ridge and its aftermath illustrate, access to first-line mental health care for rural community members, for example, is less available than in other regions of the country, let alone for second- and third-line treatments.

I therefore appeal to the committee on two fronts. The first is to consider Canadians who, like me, will feel at risk and unsafe should this legislation be enacted. The second is to acknowledge that not all Canadians will have equal access to all recommended gold standard treatments prior to undergoing MAID in a country marked by economic, geographic and cultural inequities that continue to persist despite marked efforts to address such wrongs.

● (1840)

Thank you.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you.

Now we have Dr. Thorpe.

Lilian Thorpe (Full Professor, Department of Community Health and Epidemiology and Department of Psychiatry, University of Saskatchewan, As an Individual): Thank you so much for that wonderful presentation. This is what I've heard from others as well. Thank you for your courage to speak.

Thank you for inviting me to the committee.

I am happy to give feedback on the eligibility for medical assistance in dying of people whose sole condition is mental illness or disorder. I work as a geriatric psychiatrist whose interest has focused on aging among people with intellectual disabilities, as well as other disability and aging communities. I do a lot of complex capacity assessments for a health authority. I was asked to become involved in the planning process back in 2015, prior to legalization, and I've remained provincially involved now that it has become a provincial program in Saskatchewan.

I have worked with learners at many levels, and I've had involvement in a variety of research processes. We've done projects looking at the large number of medications provided to elderly patients in the last six months of their lives, with results consistent with other data showing that we often provide treatments that are not beneficial at end of life and make end of life more difficult. I've had learners explore my data on unmet needs among people applying for medical assistance in dying, as we very much want to avoid having people end their lives because they have not had appropriate access to resources.

As an approach, we have also looked at the backgrounds of people who have applied for medical assistance in dying. We found that these were largely people with high-income, high-education backgrounds. One of our other projects, from a number of years ago, was with people who had spinal cord injuries. It was about how they felt we should deal with MAID when people with new injuries approach us for it. We got lots of feedback letting us know they feel we needed to be very cautious and involve people who have personal experience and who can give feedback before it proceeds.

I'm talking about my clinical experiences. I'm not an expert on the legal interpretations others have presented on.

This has been very clinically and ethically challenging for all of us involved directly or indirectly. We initially assessed people with severe and untreatable cancers who already had involvement with a cancer clinic and palliative care. They were people with high education and high socio-economic status to whom MAID was available. There was a lot of stigma talking about this, which meant that people were often not accessing full resources because they didn't tell people they were planning to die.

Since 2021, we've largely had people with terminal illnesses and chronic conditions starting out on track 2. These cases have been much more challenging. They have chronic mental disorders, social isolation and demoralization, and they often lack a full understanding of their resources.

I'll give you an example. I saw a homeless patient in a shelter whom I had previously met in hospital. He ended up with no medical care. He did not have his insulin. He did not have his medications for severe neuropathic pain. He didn't even know there was a nurse practitioner who could get involved in this and get his medications. Of course, we did not approve him, but we did get him connected with the appropriate resources. It's sad that it sometimes takes a MAID request to be hooked up with resources.

My primary goal with track 2 patients—these are the ones who are most similar to the patients we're talking about now—has always been to improve quality of life so they don't need to die. This is very intensive. It's somewhat better now that our provincial program has hired social workers to help connect people with resources. Before that, we were doing this, and it was many hours of work. This is a very important thing—how to set up supports for those of us doing these assessments. I don't think the rest of the country has this.

In talking about MAID for mental disorders, there are even more challenges than just track 2. People are often convinced that nothing will ever get them better. Paradoxically, some of our patients tell us that knowing they could have access to a peaceful death, as long as they become engaged with appropriate treatments, might get them to engage with those treatments long enough to stabilize them. We're seeing this with track 2. They really want to die, but they are told they can only get this once they have had some appropriate engagement.

With mental disorders, we really have a hard time knowing how it will go. It often takes years to fully stabilize, and we can't really predict it. It is particularly difficult for young people who have many years left to live. They may be more impulsive and might live long enough to see improvements in many of the interventions. I was talking to a woman in a very similar situation, and she told me that if MAID had been available when she was in her late thirties, she would have long been dead.

● (1845)

I know I'm close to my end—

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much. You have to wrap up. I'm sorry.

Lilian Thorpe: The last thing I'll mention is that there are other people who have tried everything for many years and are older people. I would still hope that we have some way of allowing them to have a peaceful death, but this will be the minority.

The Joint Vice-Chair (Hon. Pierre Dalphond): I'm sorry, but I have to cut you off, because the time is important for everybody.

Will it be Dr. Gubitz who will speak?

Gordon Gubitz (MAID Provider, Canadian Association of MAID Assessors and Providers): It's going to be Dr. Green.

The Joint Vice-Chair (Hon. Pierre Dalphond): Dr. Green, we're listening to you. You have the floor.

● (1850)

Stefanie Green (MAID Provider, Canadian Association of MAID Assessors and Providers): I appreciate both of the previous speakers. Thank you.

My name is Dr. Stefanie Green. I'm a family physician with over 30 years of clinical experience, and I've been a MAID practitioner in British Columbia since June 2016. I'm here today with Dr. Gordon Gubitz, a neurologist based in Nova Scotia, who has also been a MAID practitioner since law allowed. We have both been deeply involved in MAID training, oversight, teaching, research, and curriculum and guideline development at the local, national and international levels.

We're here today as representatives of the Canadian Association of MAID Assessors and Providers, a national professional organization that I co-founded and have helped lead for nearly a decade. CAMAP is the community of diverse professionals involved in administering and delivering assisted dying across Canada. It supports MAID professionals in their work, educates the health care community about MAID and provides leadership on determining standards and guidelines of practice within the laws of the country, all of which supports our patients, their families and hopefully one another.

I'd like to emphasize that CAMAP does not advocate for change in law. We have no role in determining what the laws of this country do or do not permit. Rather, we recognize that this is the role of Parliament. We empathize with the challenging task facing this committee, and we are pleased to be able to offer insights from our 10 years of experience.

One of CAMAP's contributions to MAID practice is the Canadian MAID curriculum. This project began when CAMAP was approached by parliamentarians to lead this initiative, and it was funded through a grant obtained from Health Canada. A peer-reviewed publication describing the extensive development framework and the robust editorial review process that was undertaken has been submitted to you for your information.

The result is a rigorously developed, comprehensive, bilingual national program, fully accredited by the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and the Canadian Nurses Association. The accreditation process of these organizations is the mechanism through which continuing professional education is determined to have appropriate quality for doctors and nurses.

The curriculum requires a significant health care background in order to understand the content. Furthermore, early modules are a foundation for later, more specialized content. This explains why, despite being asked to supply this committee with a copy of the module on MAID and mental disorders, we sent you a package outlining the entire curriculum so that you can view it in its context.

This committee's mandate is to undertake a comprehensive review relating to the eligibility of persons whose sole underlying medical condition is a mental illness to receive MAID. Part of that assessment has been to try to determine clinician and system readiness. We can attest to clinical readiness. Medical and nursing practitioners in this country are well trained and competent in assessing a patient's decision-making capacity, the voluntariness of their requests, and suicidality. These skills are, in fact, utilized every day and with every patient encounter. Professionals who have taken the Canadian MAID curriculum have further expanded and deepened their knowledge and skill set.

For the past 10 years, MAID practitioners have assessed patients with comorbid mental illness. We already have a decade of experience assessing if the mental state of an individual interferes with their decision-making capacity, if the request is truly voluntary or if they're suicidal.

When a 63-year-old woman with pancreatic cancer came to see me a few years ago for an assessment of eligibility for MAID, we also needed to discuss her lifelong bipolar disorder, the hospitalizations it required, the successful and failed treatments through the years and her history of suicidal ideation. The law required that I form a medical opinion as to whether her request for MAID was being influenced by her mental disorder, whether it was voluntary and whether or not she was suicidal. I used my training as a family physician and the extra training from CAMAP and was grateful for the input of her treating psychiatrist.

This work is doable. Also, yes, some patients may be even more complex, but as my daughter recently reminded me, some things are hard, but you can still do them.

Further readiness is evidenced by CAMAP's release of national guidance documents on assessing capacity, assessing incurability, and the approach to people with complex chronic conditions. The nationally developed model practice standard for MAID has contributed to the understanding of regulatory standards, and the Canadian Psychiatric Association has just released further guidance on evaluating eligibility criteria in persons with mental disorders and on the management of suicide risk. All of this is to say that the clinicians who are willing and interested in doing this work are ready.

Dr. Gubitz is in the room with you and will be happy to take the majority of your questions.

Thank you for your attention.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much. You're right on time.

We will start with questions from members of the committee. We'll start with the MPs. Each MP will have four minutes and 15 seconds.

We'll start with Mr. Cooper.

● (1855)

Michael Cooper (St. Albert—Sturgeon River, CPC): Thank you, Mr. Chair.

I'll direct my questions to the CAMAP witnesses.

Section 4 of module 7, on MAID and mental illness, is about specific mental disorders in MAID assessments and features the most common disorders associated with MAID requests. Common disorders featured in this section include major depression, personality disorders, trauma-related disorders such as PTSD, substance use disorder and autism spectrum disorder.

To be clear, anyone with these disorders and others, including autism spectrum disorder, substance use disorder and PTSD, could qualify for MAID in the context of having a sole underlying mental health disorder. Is that correct?

Gordon Gubitz: Yes, that is correct.

Michael Cooper: Just to be clear, it could be anything in the DSM-5.

Gordon Gubitz: It could be, as long as it meets all of the criteria related to a grievous and irremediable medical condition.

Michael Cooper: That would include things like anxiety, schizophrenia, etc. Is that correct?

Gordon Gubitz: It's entirely possible.

Michael Cooper: CAMAP is involved in developing standards and guidelines in MAID practice, and in developing curriculum and educating MAID practitioners. Is that fair?

Gordon Gubitz: We prepare guidance documents.

Michael Cooper: I take it as a given that you would agree that training and standard-setting require an objective, non-ideological, evidence-based approach.

Gordon Gubitz: That's correct.

Michael Cooper: Several recent past CAMAP board of directors members and a member of the curriculum review committee sit on Dying with Dignity Canada's clinicians advisory council. Do I have that right?

Gordon Gubitz: I would need to know the details. I'm not familiar with specific members—

Michael Cooper: I have a tough time believing—

Stefanie Green: I'm happy to speak to that.

Michael Cooper: —that you don't know about the details—

[*Translation*]

Claude DeBellefeuille (Beauharnois—Salaberry—Soulanges—Huntingdon, BQ): Mr. Chair, I have a point of order.

[*English*]

Stefanie Green: I'm sorry. I can speak to that, as I'm one of those members.

The Joint Vice-Chair (Hon. Pierre Dalphond): Just wait one second.

[*Translation*]

Claude DeBellefeuille: I want to make my colleague Mr. Cooper aware that when he interrupts a witness, the interpretation stops. The person speaking has to finish their thought before the interpreter can interpret what they're saying. In order to participate in the debate, I need to hear the interpretation. Right now, this isn't a dialogue. It's participation in a committee meeting, and both official languages need to be respected.

Hon. Pierre Dalphond: Thank you, Mrs. DeBellefeuille.

[*English*]

Mr. Cooper, give enough time after a question to let the witness complete the answer so that interpretation can be done. Thank you.

Michael Cooper: Your co-witness, Dr. Green, sits on the Dying with Dignity Canada committee, yet she served as president of CAMAP, and she was involved in the development of the curriculum. Do I have that right?

Gordon Gubitz: Dr. Green will answer that question.

Stefanie Green: Thank you. My apologies for cutting you off earlier. I appreciate the question.

In the very early days of MAID, there were very few clinicians in this country who were willing to do this work. Those of us who developed expertise in this work were asked to sit on advisory committees for a number of organizations in a number of countries.

Michael Cooper: Then the answer is yes.

Stefanie Green: We sit in that capacity—

Michael Cooper: It was a yes or no.

[*Translation*]

Claude DeBellefeuille: Mr. Chair—

[*English*]

Michael Cooper: It's my time.

Stefanie Green: We are not there to advise because of ideology.

Michael Cooper: It's my time, and she's not going to run out the clock.

The Joint Vice-Chair (Hon. Pierre Dalphond): I'm sorry, but maybe give shorter answers, because the time is running.

Thank you, Dr. Green.

Stefanie Green: It's not an ideological appointment. It's done in an advisory capacity—

Michael Cooper: I asked if you were, and you answered—

Stefanie Green: —with some of the subject matter experience.

Michael Cooper: —in the affirmative that you were.

When I look at Dying with Dignity Canada's clinicians advisory council, Dr. Valerie Cooper and Dr. Tanja Daws were involved in the curriculum update. You were involved in the curriculum update. Erica Maynard and Dr. Osmaan Sheikh were involved in the curriculum update. Dr. Konia Trouton was also involved, and she also served as the past president of CAMAP.

Members of CAMAP's board of directors and individuals directly involved in the development of CAMAP's MAID curriculum were simultaneously serving the leading pro-MAID expansionist activist organization, Dying with Dignity. How do you square that?

Stefanie Green: We're not serving them. We are there as subject matter experts on the topic.

Michael Cooper: I would say that CAMAP's claims of being objective and evidence-based are not credible given the direct ties between CAMAP and the leading pro-MAID expansionist activist organization, Dying with Dignity Canada. You have no credibility.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you, Mr. Cooper, for your remarks.

Stefanie Green: I would respectfully disagree.

The Joint Vice-Chair (Hon. Pierre Dalphond): Now we'll go to Mr. Maloney for four minutes and 15 seconds.

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

I want to thank all of the witnesses for joining us this evening. I've encountered all of you before, I believe, in previous iterations of this committee.

Dr. McKinnon, I want to start with you. You're here as somebody with lived experience, as opposed to somebody who's appearing as a medical psychologist. Is that correct?

● (1900)

Margaret McKinnon: That's correct, yes.

James Maloney: Just so I'm clear, if I understood your evidence correctly, you are anti-expansion. You do not believe that the law should allow people to apply for MAID whose sole underlying medical condition is mental illness.

Margaret McKinnon: My belief is that we are not prepared in this country for that to occur, primarily due to the inequities in the allocation of mental health resources and mental health treatments. First-, second- and third-line treatments need to be available to everyone.

James Maloney: Thank you for that.

That is based on your own lived experience, having been through a period of your life when you said you would have sought access to MAID. Is that correct?

Margaret McKinnon: Yes, I would have.

James Maloney: Okay.

Dr. Thorpe, I wasn't clear with your evidence either. Are you pro-expansion or anti-expansion?

Lilian Thorpe: I am a middle-of-the-road person who feels that it should be occasionally available in rare circumstances, but not without considerable thought and planning as to how we are going to do it safely on a clinical basis. How are we going to constitute the groups of people who look at this?

James Maloney: Thank you, Doctor.

That sort of answers my question. I'll put you in the “anti” category, because that gets to the crux of the issue, in my opinion. If we can't arrive at a consensus, then I'm not sure how, as legislators, we can recommend that we proceed.

I'm going to now move to Dr. Green and Dr. Gubitz.

Dr. Green, you were unequivocal in saying that we are clinically ready. You said that you're not here to advise on how legislators should proceed, but then you went on to say we're clinically ready and you have confidence in our system. How can you say that after having listened to Dr. McKinnon's testimony tonight?

Stefanie Green: I'm actually very much in agreement with both of the previous speakers. Dr. Thorpe just expressed very nicely that this should be available in very rare circumstances and only after careful evaluation. I think that's very consistent with what I've said and what CAMAP believes.

I would tell you that clinicians are ready, as we were ready in 2016, as we were ready in 2021 and as we will be ready—

James Maloney: Doctor, I'm going to interrupt you, because I've heard your evidence the last two times as well. The problem is that we can't pass a law that's as equivocal as you're putting forward. We have to pass a law that either allows it or not. That could put it in the hands of practitioners, and we have to trust the system.

We have had numerous practitioners appear before this committee, this time and the last two times, who said we are not clinically ready and the system is not prepared for multiple reasons, including the fact that we don't have resources. What do you say to that and how do you answer that question after hearing from Dr. McKinnon?

Gordon Gubitz: The position—

Stefanie Green: I think those clinicians are not ready and so they should not be involved in the work. The few people who are ready could be involved in the work.

James Maloney: Doctor, with all due respect, you know as well as I do that there will be doctors involved in the process who may not have the same level of ethical standards and professional approach to this issue as you do. How can I, in all good conscience, when I have doctor after doctor and professional after professional coming here telling me we're not ready for that reason...? In fact, if I'm not mistaken, you have said in the past that lack of consensus is not a reason to proceed. In my respectful opinion, that is a reason not to proceed.

Stefanie Green: This committee is not going to reach a consensus, and I expect that they will proceed. I expect the Supreme Court doesn't reach a consensus and they will proceed. I expect you can make a difficult decision.

James Maloney: Yes, we're in the business of making difficult decisions, but these decisions are irreversible. What you're asking us.... You're telling us that we have a system that is ironclad and ready to go in passing a law that allows people to end their life. After hearing from Dr. McKinnon, I just don't know how you can say that with any degree of confidence whatsoever, Doctor.

Stefanie Green: Was there a question there?

The Joint Vice-Chair (Hon. Pierre Dalphond): That was more of a comment than a question.

James Maloney: Thank you.

The Joint Vice-Chair (Hon. Pierre Dalphond): The next questions will be from Madame DeBellefeuille.

[*Translation*]

You may go ahead. You have four minutes and 15 seconds.

Claude DeBellefeuille: Thank you, Mr. Chair.

Thank you to the interpreters for the excellent job they're doing.

Mr. Gubitz, until March 31, I was a social worker and a member of my professional association. I am a professional who believes in medical assistance in dying, who has advocated for that right and who defends it. Nevertheless, giving people whose sole medical condition is a mental illness access to MAID is very concerning to me. There doesn't seem to be a clinical consensus on how to determine whether a mental illness is irremediable. The irremediability of a condition is more or less the clinical test for determining whether a person is eligible to receive MAID or not.

Can you tell us how you define an irremediable mental illness?

● (1905)

[*English*]

Gordon Gubitz: The definition of "irremediability" has been discussed at this committee for the last three sessions by experts in psychiatric disease and by legal scholars.

Practically speaking, from the point of view of the Canadian Association of MAID Assessors and Providers, we were required, as requested by Parliament, to come up with training that would allow the average physician and/or nurse practitioner to be engaged in the sort of clinical practice that would allow them—over time and with extensive consultation with the patient, those who support them and those who treat them, and with other collaborative approaches—to really understand the fullness of a person's experience.

In terms of irremediability, that's very difficult to assess in a day, a week or a month. Obviously, we're looking for probably many years of treatment, with all of the technologies, medicines and resources that are available, and with the support of experts in a particular illness, disease or disability. We know that not every clinician who is involved in MAID work will have the experience to deal with every patient who sits in front of them.

[*Translation*]

Claude DeBellefeuille: As we know, Quebec has been a leader in advancing MAID, even authorizing advanced requests, which will be allowed even though the Criminal Code wasn't amended. Quebec is moving forward but is apprehensive about expanding MAID access to people whose sole medical condition is a mental illness. It even shut the door on the possibility in 2023, when its last report came out, citing the absence of a strong clinical consensus and especially the fact that professionals weren't necessarily ready to receive and assess such requests.

Do you have an opinion on the work Quebec has done in this area?

[*English*]

Gordon Gubitz: As a representative of the Canadian association, I don't have a specific opinion about what's gone on in Quebec, but I can speak more nationally. Quebec, of course, is a member of the Canadian Association of MAID Assessors and Providers. Many members from Quebec are there and are involved with our work.

I think what you're speaking about right now is clinical readiness, so how do we determine clinical readiness? We have the Canadian MAID curriculum. You have been provided with a copy of it as well as the paper about the development of the process. We also have guidance documents produced by CAMAP that talk about the very specific things that Dr. Green mentioned in her opening remarks. We have an online assessor forum through the CAMAP group, an online provider forum, and this allows in-time conversations to be held between clinicians to talk about difficult cases. These are all protected by a firewall sort of thing. We have regular difficult case scenario conferences that CAMAP members are invited to attend. They come, they present a case and they hear experts from across the country talk about that.

As Dr. Green mentioned, we have a national CAMAP meeting—it's happening this Thursday, Friday and Saturday in Montreal—and many of the things that are being discussed around this table are being presented as plenary sessions, with lots of complex discussion. Supportive documents include the Canadian Psychiatric Association document, which deals with these things, and the model practice standard, and we have the advice of professionals.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you, Dr. Gubitz.

The Joint Chair (Marcus Powlowski (Thunder Bay—Rainy River, Lib.)): We'll turn now to questioning by senators.

I would note that since Senator Dalphond is not going to ask a question, we can give them each three minutes.

We'll start with Senator Moodie for three minutes.

Hon. Rosemary Moodie (Senator, Ontario, ISG): Thank you, Mr. Chair.

Dr. Gubitz, you've encountered individuals who have made suicide attempts in the past. You've encountered individuals who say that if they're not found eligible for MAID, they will complete a suicide attempt. You've encountered individuals who have suicidal thinking at the time of the request. Is this so? Is suicidality something that arises in MAID practice, even though persons with mental illness as the sole underlying cause are excluded right now?

● (1910)

Gordon Gubitz: As clinicians, we encounter patients who have suicidal thoughts, actions and ideations in every aspect of our clinical work. [*Technical difficulty—Editor*] who has recently been diagnosed with ALS.

Hon. Rosemary Moodie: I have another question. Really, I'm finding it very interesting to listen to the discussion.

In my experience, when there is no expertise available in a particular town, province or location in this country, physicians don't just get up and provide that service. If expertise is not available, unfortunately a service is not available. Is it your expectation that there will be physicians who suddenly decide they're going to provide MAID, even without the expertise that is needed?

Gordon Gubitz: According to everything we understand from how assessments are to be done and the regulations around that, it's not possible to complete an entire MAID assessment without the opinion of somebody who has expertise in the condition. If I assess a patient who has a high spinal cord injury, and I have no expertise in that area, I am compelled to speak to a colleague or make a referral to somebody who has that expertise.

I could give you an example, if you wish.

Hon. Rosemary Moodie: Could you? Thank you.

Gordon Gubitz: I followed a patient with trigeminal neuralgia, a very painful facial disorder. The young woman did not tolerate any of the medications. She had two separate surgeries to require this to happen. She came to me asking for MAID after she'd lost 40 pounds and was no longer able to eat except very painfully.

I referred her back to the surgeons, who did a cross-country assessment. They had a video conference call about this person in particular to determine whether or not anything else could be done for her. We sent her to pain specialists, who were not able to add anything else. She went on to have a medically assisted death at a weight of 70 pounds.

Hon. Rosemary Moodie: Thank you.

Mr. Chair, I assume that I have no more time.

The Joint Chair (Marcus Powlowski): Thank you.

Next is Senator Osler for three minutes.

Hon. F. Gigi Osler (Senator, Manitoba, CSG): Thanks, Chair.

Thank you to all the witnesses for being here today.

Dr. Gubitz, we've been told that the justification for the exclusion is that mental disorders and physical disorders are different. The way they are different is that mental disorders do not have a predictable course, but physical disorders do. Can you give some examples of neurological conditions that do not have a predictable course?

Second, when you have to determine if a person's neurological condition is a grievous and irremediable medical condition, and the prognosis is not certain, how do you come to a determination on whether the person's condition fulfills this criteria?

Gordon Gubitz: In terms of specific neurological disorders, one might think about certain types of movement disorders, such as Parkinson's disease, which could have a variable presentation lasting from several years to dozens of years, in which case a person has to go through life with those symptoms and try to manage as best they can. Some of the neurodegenerative problems and certain of the less common dementias may have presentations like that.

On the second question, for people we have not yet determined have a grievous and irremediable medical condition, in most serious neurological disorders the answer is time. In serious neurological disorders, things get worse over time. The example, once again, is something like motor neurone disease or ALS, where you're starting off with a twitch in a foot and ending up in a wheelchair two years later, fed by a tube.

Hon. F. Gigi Osler: I think I have time for a third question.

We've also heard testimony that the CAMAP curriculum has not dealt appropriately with ableism embedded in our society. Can you respond to that?

Gordon Gubitz: Ableism is mentioned in several different components of the curriculum. The most notable would be in topic four, which assesses capacity and vulnerability. There are specific bits within the curriculum that deal with ableism.

I'll finish with some advice we provide to assessors and providers.

The first is that they acknowledge that persons with a disability requesting MAID have experienced trauma and that the medical system and society at large may have contributed to this. This would be an acknowledgement that this exists for a person with a disability.

The second is avoiding presumptions about their experience and making sure they're engaged in specific and detailed conversations within the context that the patient will allow us to be involved. Sometimes that involves collaboration with other health professionals, social workers, case workers and people they have been involved with.

The third and perhaps most important part is to try to distinguish between the suffering caused by the medical illness, disease or disability and the suffering caused by injustice, discrimination, stigma and exclusion. That's hard to do. They can be interwoven.

There's no perfect answer to this; I will agree with that, but we must—

● (1915)

The Joint Chair (Marcus Powlowski): Thank you, Dr. Gubitz.

Senator Wells, you have three minutes.

Hon. Kristopher Wells (Senator, Alberta, PSG): Thank you.

My questions are for Dr. Gubitz.

We've heard a lot about consensus. From your perspective, can you tell me whether there was consensus when track 1 came in?

Gordon Gubitz: Casting my eye back, I think because the parameters were so small—grievous and irremediable—and there was no mention of track 2 at that time, when MAID practice originally began with track 1—Dr. Green can speak to this, and I believe Dr. Thorpe can as well—we were basically, if you'll pardon the expression, reaching for the low-hanging fruit. These were people who were at the very end of their lives and were suffering tremendously, mostly from cancer, end-stage heart failure or end-stage failure of another organ, and clearly met all the criteria.

Hon. Kristopher Wells: I'm going to switch to the curriculum.

Can you speak about the consultation that's been done to design the curriculum and what you've heard from clinicians on how they are using the guidance?

Gordon Gubitz: A document was submitted through the clerk called the “Development of a Canadian Medical Assistance in Dying Curriculum for Healthcare Providers”. It exists as a document and it provides all the detailed background. Those of us involved in medical education are not educational experts, so we relied on Queen's University's department of higher education to put us through an entire process that was very evidence-based and that adopted the highest of educational standards.

In the feedback we've had on the curriculum thus far, well over 95% of the people who attended the curriculum felt it was beneficial and would have improved their MAID practice, and a good proportion of those who had not provided MAID were interested in beginning to incorporate MAID into their careers.

Hon. Kristopher Wells: With the recent guidance and materials that have been developed, can you talk about the particular gaps you were trying to address?

Gordon Gubitz: I'm sorry; gaps with respect to....

Hon. Kristopher Wells: From what you've heard, in moving to the sole underlying condition of mental illness and the new guidance and materials, what was missing from the knowledge that providers had that you have now been able to provide them?

Gordon Gubitz: The development of the curriculum allowed folks to go through the curriculum from the beginning to learn how to do an assessment, etc., through vulnerability and capacity, complex cases and all of the other modules to get to module 7. Very few people would have taken the seventh module as a stand-alone, because it presumed a significant amount of background knowledge of all the issues that have come before.

I think people who have taken the curriculum of module 7 are better prepared than the average person to deal with the question about mental health as a sole underlying condition, and we would encourage more people to partake in the curriculum as it goes forward. We think it's an excellent product.

Hon. Kristopher Wells: How many hours would you say the totality of that curriculum is?

Gordon Gubitz: It's 27 hours for the entire curriculum.

The Joint Chair (Marcus Powlowski): Thank you.

The Joint Vice-Chair (Hon. Pierre Dalphond): We'll now move to the second round with MPs.

Mr. Patzer, you have two minutes and 33 seconds.

Jeremy Patzer (Swift Current—Grasslands—Kindersley, CPC): Thank you very much.

Ms. McKinnon, as a mental health professional, a person with lived experience and an internationally recognized expert in traumatic stress, can you distinguish between suicidality and the desire to die?

Margaret McKinnon: No, I cannot. When I was experiencing suicidality in relation to MAID, I did not distinguish between the desire to die, suicidal ideation and suicidal intent. I just cannot make that distinction as a person with lived experience.

As a professional, I know that for things like “not criminally responsible”, we have reliable and valid scales to assess them, and I don't think we should be holding this decision to a lower standard of evidence.

Jeremy Patzer: You said that if MAID for mental health had been available during your period of severe illness, you believe you may not be here today. In your view, what does that say about the danger of treating as irremediable the desire to die of a person who has a mental illness?

● (1920)

Margaret McKinnon: It's very difficult to conclude that someone has no hope for recovery. One of the hallmarks of a mental health condition, which certainly I know as a person with lived experience, is a belief that it will never end. I certainly felt that way during a time of prolonged depression. That's part and parcel of the disease and the condition, but I think to make the judgment that there is no hope is really difficult. I don't envy health care professionals who have to make that decision. I think it's going to be very difficult for them, should this go through.

Jeremy Patzer: Thank you for that.

Finally, you said you had good mental health care, financial means, social support and professional knowledge, yet you still felt at risk. If someone with those supports could feel unsafe under our current system, what does that mean for Canadians who are poor, isolated, living in rural and remote communities, disabled or unable to access specialized care or the first, second and third lines of treatment you referred to?

Margaret McKinnon: This troubles me deeply, because if we look at international and national guidelines, we have recommendations for first-, second- and third-line therapies. Those are both pharmacological and non-pharmacological treatments. Many Canadians, as we know, have difficulty accessing first-line treatments to get access to treatments that have less evidence but have shown effectiveness for some individuals. I just don't see that happening in our country. I'm sure there are statistics that would support that.

[*Translation*]

Claude DeBellefeuille: I have a point of order, Mr. Chair.

The witness isn't speaking loudly enough, so the interpreter can't interpret what they're saying.

[*English*]

The Joint Vice-Chair (Hon. Pierre Dalphond): Please move closer to your microphone. We didn't get the last part of your answer.

Margaret McKinnon: Would you like me to repeat my answer?

The Joint Vice-Chair (Hon. Pierre Dalphond): Yes, please repeat the last part of your answer.

Margaret McKinnon: Certainly.

If we look at national and international guidelines surrounding the treatment of mental health conditions, there are often recommendations, if not in all of these guidelines, for first-, second- and third-line therapies. Those are both pharmacological treatments and psychological treatments.

The majority of Canadians, as we know, may have difficulty accessing a first-line therapy for a mental health condition, let alone the second- and third-line therapies. Where these inequities exist in Canada, it really troubles me that some people will receive MAID for mental health after having received access to all three, particularly if they have financial means. For those who do not.... We can think, for example, of individuals living in Pangnirtung, Nunavut, for whom there's almost a complete absence of mental health and well-being resources.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much.

[*Translation*]

We now go to Ms. Koutrakis.

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

[*English*]

My questions will be for Dr. Green and Dr. Gubitz.

Do you think systems of MAID oversight and quality assurance are adequate and consistent across Canada?

Gordon Gubitz: The systems of oversight across Canada are provincially and territorially regulated and will vary from province to province and jurisdiction to jurisdiction. There are many groups that have a retrospective chart review and audit, like the Ontario system. There are systems where I'm from in Nova Scotia that have both prospective and retrospective reviews of cases in an arbitrary sort of way.

It's difficult to speak to the totality of the Canadian experience. I think each province and territory is obligated to ensure that regulatory standards are upheld to the level that they can be. That's very important.

Annie Koutrakis: Is there something you wanted to add, Dr. Green or Dr. Thorpe?

Stefanie Green: Yes.

Of course, there are the federal legislative requirements for oversight that we just spoke to, and there are territorial oversight mechanisms. There are also professional standards that physicians need to follow that are upheld in every region of the country, and there are often local facility or regional guidelines. There are quite a few layers of oversight out there, and we know that at least 90% of all cases are individually reviewed in the country, according to Health Canada data.

Annie Koutrakis: Dr. Thorpe, would you like to comment on that?

Lilian Thorpe: I'm sorry, but I don't have anything to add to that.

It does certainly vary across the country.

Annie Koutrakis: If a consensus is not required in medicine—and we've heard this several times—what threshold of clinical disagreement would, in your view, justify delaying implementation? It sounds to me like it varies across the provinces and territories. What do we need to be mindful of to make sure that the threshold of clinical disagreement justifies delaying implementation?

Dr. Thorpe.

● (1925)

Lilian Thorpe: That's a tough question. I don't have a good answer to that.

I'm going to pass that to Gord or Dr. Green.

Gordon Gubitz: Clinical medicine always involves disagreements or differing opinions, depending on how the evidence is acquired, how the patient is examined and the information they provide. One of the reasons we have two assessments for each patient is to ensure that we have a consensus of opinion around the individual case itself.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you.

[*Translation*]

Over to you, Mrs. DeBellefeuille.

Claude DeBellefeuille: Thank you.

Mr. Gubitz, in your practice and given how the practice is developing, would someone experiencing depression and suicidal thoughts be eligible for MAID?

[*English*]

Gordon Gubitz: Briefly, no. If the person is actively suicidal, assessments for MAID are off the table.

We need to ensure that the person has been referred to the appropriate mental health services. We occasionally encounter a circumstance where we find somebody ineligible and they say, “Well, I'm just going to kill myself, then.” My response to that is to telephone the police and do a wellness check on them to ensure they are going to get the care they require, in addition to speaking to the care providers who have referred them to me.

[*Translation*]

Claude DeBellefeuille: Would a person experiencing depression who tries to kill themselves, ends up in hospital and requests MAID be eligible to receive it?

[*English*]

Gordon Gubitz: Once again, I think the clinical scenario would have to allow for some degree of stability over time to ensure that they are outside of the crisis that resulted in the suicidal ideation. Referring to the Canadian Psychiatric Association document around how clinicians go about assessing patients for suicidality would be a reasonable standard for across the entire country. It's very well laid out.

[*Translation*]

Claude DeBellefeuille: We can assume, then, that access to MAID would not be easily granted to someone experiencing suicidal ideation, because clinically, it would have to be shown that every attempt had been made to provide the person with support and get them through the crisis.

[*English*]

Gordon Gubitz: I agree, and once again, that depends upon the individual circumstances of a patient. We have encountered people who have—

The Joint Chair (Marcus Powlowski): The time is up.

Gordon Gubitz: I'm terribly sorry.

The Joint Chair (Marcus Powlowski): We'll now go to Senator Moodie for one minute and 42 seconds.

Hon. Rosemary Moodie: Thank you, Mr. Chair.

I want to ask Dr. Green and Dr. Gubitz a question.

I'd really hate for the general public who are listening to the discussion this evening to come away with the idea that physicians in Canada are reckless and uncontrolled and they practice procedures and medicine that they're untrained for—essentially, that they're unethical.

The first part of my question is this: In your opinion, will practitioners who are not properly trained and do not adhere to professional standards get involved in complex MAID cases?

The second part of my question is this: Is it not the case that physicians have a professional obligation to only practise within their scope of practice, i.e., within their professional competencies?

Gordon Gubitz: Thank you for the question.

Hon. Rosemary Moodie: I'm sorry to interrupt, but is there not a process by which people can complain if any physician is found to be acting outside their scope of practice?

The Joint Chair (Marcus Powlowski): Dr. Gubitz, you have 30 seconds.

Gordon Gubitz: Physicians are obligated to practise within their scope of practice and their standards according to their provincial or territorial college. Medical assistance in dying is no different.

Unethical people practise across the sphere of medicine and will do what they will. We do not encourage them to be involved with our work.

Stefanie Green: May I add something?

The Joint Chair (Marcus Powlowski): No. I'm sorry; we're out of time.

We'll go to the next senator.

Senator Osler, you have one minute and 46 seconds.

● (1930)

Hon. F. Gigi Osler: Thank you, Mr. Chair.

My question is for Dr. Green.

To follow up on something you mentioned in your opening remarks, is there peer-reviewed, empirical evidence that talks about socio-economic vulnerability and marginalization as drivers of requests for MAID?

Stefanie Green: There's actually some very good data on this exact question, and it has been grossly misinterpreted and put out there. Dr. James Downar has a number of publications in which he reviews the data and clearly states that those who are receiving MAID in this country are socio-economically advantaged. It's very clear that they're more likely white, that they're more likely well-educated, that they're more likely socio-economically and financially stable, and that they are less likely to live alone.

There are a number of parameters that he has proven over a number of papers. I think that's been very clear.

Hon. F. Gigi Osler: I'm going to ask you a question I asked in the first panel about the criticism that the CAMAP curriculum has not dealt appropriately with the ableism embedded in our society. Can you respond?

Stefanie Green: There's been some question about that. I think working group four, which Dr. Gubitz pointed out, did the most work on this. We had about 18 months to two years of work. We had input from a witness who came before this committee, which was very valuable and was incorporated. We're better off for that.

I think we've dealt with it. I think the outline will demonstrate to you the number of times that vulnerability and ableism are commented on and dealt with in the curriculum. I think Dr. Gubitz has addressed the rest of that question.

Hon. F. Gigi Osler: Finally, can you tell us how many hours—

The Joint Vice-Chair (Hon. Pierre Dalphond): Actually, your time is up.

I wish to thank our witnesses.

I will now suspend in order to proceed with our second panel.

● (1930)

(Pause)

● (1935)

The Joint Vice-Chair (Hon. Pierre Dalphond): We'll resume with the second panel.

As an individual, we'll hear from Dr. Eliana Close from Australia. Representing 9-8-8: Suicide Crisis Helpline, we have Dr. Allison Crawford. From the College of Physicians and Surgeons of Nova Scotia, we have Dr. Douglas Grant.

The floor is yours, Dr. Close.

Eliana Close (Senior Research Fellow, Australian Centre for Health Law Research, Queensland University of Technology, As an Individual): Members of the committee, thank you for the opportunity to appear before you today.

I'm a researcher at the Australian Centre for Health Law Research at Queensland University of Technology in Brisbane, but I'm originally from Calgary. I did my undergraduate degree at the University of Calgary and my law degree at Oxford as a Rhodes Scholar. I articled at the Alberta Court of Appeal and was a Crown prosecutor in Alberta, and then I immigrated to Australia and entered academia.

I have a Ph.D., and I have been researching end-of-life law, policy and practice for the last 14 years, with a focus on assisted dying. Over the past five years, I led a Canadian case study on MAID as part of a major Australian Research Council project on the optimal regulation of assisted dying. The study included law and policy analysis and qualitative interviews with persons engaged in MAID delivery and regulation. I have published extensively in this area, and I appear today in my personal capacity as a researcher.

I want to offer the committee three interconnected messages that have come out of my research.

First, the regulation of MAID is much broader than law alone, and that matters enormously for assessing readiness. A recurring error in public debate is to treat the Criminal Code as the only regulatory tool for MAID. Regulation is about shaping and steering behaviour and encompasses far more than just legal rules. Guidelines, training, institutional practices and communities of practice are all part of regulation. Optimal regulation includes both detecting transgressions and promoting best practices and continuous quality improvement. One cannot and should not put everything in the law. Readiness for MAID for mental illness as a sole underlying condition should therefore be examined holistically by looking at the whole regulatory ecosystem.

Second, oversight and monitoring of MAID in Canada are robust, and the system already has considerable strengths. I've published several articles on oversight and monitoring, and here it is worth being precise about terms, because conflation of monitoring and oversight is common. Monitoring is about aggregate data: tracking who's accessing MAID and under what conditions. Oversight is about review of individual cases for compliance with law and applicable standards. Both are important.

Regarding monitoring, Canada's federal system is rigorous. Preliminary assessors, MAID assessors and providers, and pharmacists all report to Health Canada. MAID is one of the most comprehensively reported medical practices in the country. All requests are reported and multiple practitioners report on every single case, and Health Canada's annual reports on MAID are among the most detailed in the world.

Regarding oversight, over 90% of MAID cases have some form of retrospective oversight, and this is because the most populous provinces have bodies that do this. Quebec's commission on end-of-life care reviews every MAID case and publishes reports. Ontario's chief coroner has a MAID review team, the MRT, which is different from the MAID death review committee, which has a different role. The MRT is a team of nurse coroners that reviews every case and produces annual reports. British Columbia and Alberta also review every case. These are meaningful mechanisms of accountability and scrutiny.

Third, the coal face regulation is a critical and underappreciated component of MAID regulation. Some of the most powerful regulation in medicine occurs at the clinical coal face—in other words, the front line of health care delivery. Coal face regulation extends formal regulation into day-to-day practice and includes clinical practice recommendations, peer consultation and best practices established by MAID teams in institutions and health authorities. For example, Nova Scotia has a single province-wide team that is aware of every MAID case and provides prospective support and retrospective quality review.

In summary, Canada's MAID system has real regulatory strengths, strong oversight, comprehensive monitoring and a layered ecosystem. The challenges for mental illness as a sole underlying condition are genuine, and they call for targeted regulatory responses. While the Criminal Code sets the framework, it is mechanisms like clinical guidance and coal face regulation that are best placed to deliver them.

I welcome the committee's questions.

● (1940)

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much, Dr. Close.

Dr. Crawford, you have four and half minutes for your remarks.

Allison Crawford (Chief Medical Officer, 9-8-8: Suicide Crisis Helpline): Good evening, committee members. My name is Dr. Allison Crawford. I'm a psychiatrist and the chief medical officer for 9-8-8: Suicide Crisis Helpline. I'm a professor at the University of Toronto and also the principal applicant on a CIHR-funded study examining MAID and suicide in the crisis line context.

I'll be direct. I do not believe Canada should expand MAID to include those whose underlying condition is a mental disorder. I'm basing that on four core points: what we're seeing at 988, the absence of evidence that requests for MAID for mental disorder can be reliably distinguished from suicidal intent, shortcomings of recent clinical guidance, and public health and media risks.

First, on frontline signals from 988, up to 7% of interactions on the service refer to MAID. Critically, among those who reference MAID, 74% endorsed thoughts of suicide in the past two days, compared with 48% among other contacts. In short, interactions with our national suicide crisis line that reference MAID are associated with substantially higher suicidal ideation. That's not a theoretical concern; it's a real, measurable, elevated risk among people who mentioned MAID to Canada's suicide prevention service.

Second, we know that suicidal thoughts and behaviours are very common across psychiatric diagnoses, and they are treatable. Our systematic review of peer-reviewed literature found no credible evidence that suicidal intent can be reliably distinguished from an interest in MAID when the sole underlying condition is a mental disorder. Both suicide and MAID represent an intention to die. Both often stem from the same underlying drivers: psychiatric disorder, intolerable suffering, hopelessness, perceived burdensomeness, and often social adversity. We also found no validated tools or assessment instruments that can reliably discriminate suicidality from a reasoned wish to die in the MAID context.

Third, recent guidance from the Canadian Psychiatric Association does not resolve these clinical or operational gaps. The guidance is largely aspirational. It asks assessors to differentiate acute suicidal risk from a well-considered wish to die, but offers no operational framework, no clear criteria and no specification of structured tools. The guidance also fails to incorporate a standardized equity assessment to determine when social determinants and remediable needs are driving suffering. In practice, this leaves clinicians without the evidence-based procedures needed to safely assess risk or to embed suicide prevention into MAID pathways.

Fourth, there are public health risks in the way that MAID and suicide are discussed publicly and in the media. Our recent research, currently submitted for peer review, highlights that the media often conflates MAID with suicide, or fails to use established, responsible media guidance for reporting on suicide. We lack guidance on safe communication about MAID and on preventing contagion effects, which should be a concern in making MAID for mental disorder an option. As it becomes more visible, the absence of responsible public messaging increases the risk that people will see MAID as a means of alleviating their mental suffering. This will undermine suicide prevention efforts.

Additionally, we must also [*Technical difficulty—Editor*] all the services across Canada remain under-resourced, with long waits and inequitable access. These circumstances can produce or exacerbate the suffering that may drive MAID requests and suicidal thoughts and behaviours.

My recommendation is straightforward. Do not expand MAID to cases where the sole underlying condition is a mental disorder. This recommendation aligns with the position of the International Association for Suicide Prevention that the overlap between MAID requests and suicide makes distinguishing between them impossible. MAID for mental illness will undermine suicide prevention by positioning MAID as a viable alternative to treatment.

Suicide is preventable. The vast majority of people who contemplate or attempt suicide do not go on to die by suicide. Public health approaches to suicide prevention have been a priority in Canada, which is one of the reasons that the establishment of 988 received unanimous support in the House of Commons. Given the significant overlap between suicidal thoughts and behaviours in MAID, we will best serve those who are suffering by enhancing suicide prevention efforts and by shifting our focus to medical assistance in living. That is what Canadians deserve.

Thank you.

● (1945)

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much, Dr. Crawford.

Now we'll go to Dr. Grant, who is also a representative of the Federation of Medical Regulatory Authorities of Canada.

Douglas Grant (Registrar and Chief Executive Officer, College of Physicians and Surgeons of Nova Scotia): Thank you.

I'm the registrar of the College of Physicians of Nova Scotia. I have been since 2011. Before that, I practised law and family medicine for many years. It's a privilege to make these submissions.

The committee has had read into its record a letter from the Federation of Medical Regulatory Authorities of Canada. I was one of the signatories to that letter. To summarize its essence, wherever the law lands on medical assistance in dying, the regulatory colleges will be ready.

My submission—and I'm here on behalf of my own college—is that the college in Nova Scotia will be ready because it's our legal duty to be ready.

As a medical regulator, our college must keep pace with change in medicine. Otherwise put, medical regulators can't be the rate-limiting step for medical progress. We haven't been for MAID, and we won't be if MAID changes. Recent history supports that.

When the world changed with the pandemic, the regulators were the enablers of medical change. I think of the hours spent on vaccine mandates, on public health orders, on virtual medicine and on remote prescribing. On all of the things that were required in the moment to make medicine work, the regulators were at the front.

For MAID, additional time won't help us. Additional time in and of itself will not materially advance the regulation of MAID in Nova Scotia. If the law changes, we'll make the necessary regulatory changes, which will involve changing professional standards, communicating with the public and communicating with the profession. We'll respond to questions from the public. We'll investigate complaints to hold physicians accountable. We'll do what's necessary.

On the surface, Nova Scotia's regulatory experience with MAID has been smooth, as has been the country's as a whole. At each punctuation mark, we've made the necessary changes in standards and communicated with the profession. We've kept step with the law. We've kept step with practice.

Since it was introduced, since MAID became part of clinical medicine in Nova Scotia, our college has investigated around 4,000 complaints. Three of them have involved MAID, and all three involved cases where family members were unable to access an assessment for MAID by a conscientiously objecting physician. These complaints were resolved through advice and education, not through discipline.

Most regulation takes place behind the scenes. I appreciate Dr. Close's comment about regulation at the coal face. For me and for MAID, there have been lots of meetings to provide advice, there's been engagement with advocacy and faith-based groups with conscientious objections and there have been discussions with institutions seeking to assert policies inconsistent with the law. Some of these meetings have been difficult, but overall, the regulatory burden associated with MAID has been less than this chamber might anticipate.

When I spoke to this committee—and I think I've given evidence two or three times to this committee or predecessor committees—the questions of regulatory readiness were raised at each significant juncture, each significant punctuation mark with MAID. They were raised following the Carter decision. They were raised in the debates about Bill C-14 and Bill C-7. They were raised in contemplation of Audrey’s amendment.

At least in my experience, each time I was asked questions about regulatory readiness, they came from voices known to be opposed to MAID for other reasons. I urge this committee to examine the question of readiness as readiness per se and not as a proxy for other reasons.

I see four domains of readiness. The first is legal, and the Carter decision is your foundation.

The second is political. By the way, I'm grateful for the service of the people sitting in these chairs who work on questions of political and legal readiness.

The third is regulatory readiness. I really appreciate Dr. Close's analysis of the matrix, the filters and the various levels of regulation, but from the purely medical regulatory authorities' perspective, I'd submit that that shouldn't be a determinant of your deliberations.

● (1950)

The fourth, of course, is clinical readiness. You're clearly hearing significant evidence about that. I would submit that Nova Scotia's clinical approach is extraordinarily robust, and I have tremendous confidence in it, but that's your decision to make.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you, Dr. Grant.

We're ready for questions now. The first questions will be from Ms. Jansen.

You have four minutes and 15 seconds.

Tamara Jansen (Cloverdale—Langley City, CPC): Dr. Crawford, you said that up to 7% of calls to Canada's suicide crisis line have people mentioning MAID as an option. The majority of those callers had thoughts of suicide in just the previous two days. If I understand that right, when MAID comes up in those 988 calls, you're talking to people who are much more likely to be in an acute suicidal state compared to the ones who don't mention it. Is that a fair understanding of what your data is showing?

Allison Crawford: Yes. We're still analyzing this as we go. As you know, 988 is a relatively new service, but we've had almost 900,000 calls and texts to the service. Seven per cent represents almost 70,000 interactions.

What we're finding is that when people reference MAID, they have a much higher degree of suicidality than callers and texters who don't reference MAID. The key point here is that people make a lot about being able to distinguish suicidality from a wish to die due to MAID, and we are seeing a great deal of overlap in those populations. They're clearly suffering, but it's suffering that overlaps.

Tamara Jansen: Dr. Crawford, with the way MAID is talked about in the media, it seems that they are completely unaware of the danger of suicide contagion. We hear and see portrayals of MAID in serene and dreamy surroundings, with the idea that this kind of death is heroic and self-sacrificing, which is, of course, very opposite to the suicide prevention messaging.

Normally, we don't amplify or glorify the actions of, say, a shooter, for example, in order to avoid copycat behaviour. How real is the risk of suicide contagion with our media reporting and messaging, and what immediate communication safeguards should be in place to prevent that kind of effect?

Allison Crawford: In Canada and internationally, we've made great strides in responsible media practices when media mentions suicide, but when we looked at articles that mention both MAID and suicide, we found that the safe and responsible reporting practices were not followed. There was a glorification of death. There was a lot of stigmatizing language in a vast majority of articles.

We know that that has very real effects. Certainly in the suicide prevention world, there is a demonstrable effect, called the Werther effect, that results in many deaths. This does apply to MAID. We've already seen that in the Netherlands. When there are media cases with a lot of attention, we see increasing requests for MAID. It's a very real effect, and we should be very concerned about contagion.

Tamara Jansen: When the Simons advertisement came out, which definitely glorified MAID for somebody, could you see in the calls to 988 that there was an impact?

Allison Crawford: We didn't look at that specific ad campaign, but we have looked at different legislative time points and can definitely see an impact.

I'm sorry; that's in media reporting, not to 988. We have not looked at that in terms of calls to 988.

Tamara Jansen: What specific evidence gaps did your literature review identify about distinguishing MAID requests from suicidal intent? What would be required to fill those gaps?

Allison Crawford: We just completed a systematic review of the literature and found a lot of overlap and inconsistency in how research—the published peer-reviewed literature—was talking about and defining suicide in relation to MAID.

In many of these debates, they're treated as very distinguishable, but in the scientific literature, that distinction is not clear. We also found no standardized tools that could reliably distinguish between suicide and an interest in dying from MAID.

I'm not sure we can get there such that we are able to distinguish between them. They are overlapping concepts. They're both an intention or an interest in dying. They're both signs of despair or thoughts of despair.

● (1955)

Tamara Jansen: Where does the Canadian Psychiatric Association guidance fall short in practice?

Allison Crawford: Primarily the concern is that it tries to say that a gap has been filled that has not been filled. It tries to advance that we are closer to making differentiations around irremediability and suicide.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much.

The next round of questions will be from Dr. Powlowski.

Marcus Powlowski: I have to say, Mr. Vice-Chair, as a greenhorn in this business, you're doing really well. For those who don't know, you were a Quebec Court of Appeal judge before you came here. You're going to hit me with the hammer next.

The question is whether we should expand MAID for mental illness. Certainly, we've heard from Professor Close about the comprehensive oversight available in Canada. Dr. Green talked about the robust professional oversight. Dr. Grant talked about being ready. There would be professional oversight.

It's hard for me to believe this, given the kind of oversight of MAID we've currently been seeing and the lack of cases that have come before the colleges of physicians and surgeons across Canada. For example, Professor Close talked about a coroner's MAID review team. According to them, there have been 14 cases referred by the Ontario coroner's office to the CPSO. To my knowledge, there has been no disciplinary action.

I've been a member of the College of Physicians and Surgeons of Ontario for 40 years. I know the College of Physicians and Surgeons. If they got a medical complaint about my practice, there would certainly be a review. It would be sent to all members of the College of Physicians and Surgeons. This doesn't seem to be the case with MAID.

Similarly, a freedom of information request in B.C., in 2023, found that there were two dozen cases referred to police, colleges of physicians and surgeons or colleges of nurses regarding MAID practitioners. Again, there are seemingly no cases, yet there have been some egregious cases. One example is the case involving Dr. Wiebe, which is currently in the courts. There was a patient hospitalized for suicidal ideation. While out on leave, they saw a MAID practitioner and received MAID.

Dr. Maher, an ACT team doctor in southern Ontario, talked about a patient of his with chronic schizophrenia. I might add that he was asked to appear here but has so far said no. He didn't want to appear. Both he and the family physician said that this patient clearly did not meet any of the requirements to get MAID, but he'd seen two doctors and had been approved. When Dr. Maher went to the College of Physicians and Surgeons of Ontario, they said, “Well, you'll have to wait until he has actually died before you can....”

I know, Dr. Grant. You're looking.... That's the way I feel.

The Joint Vice-Chair (Hon. Pierre Dalphond): You have one and a half minutes left.

Marcus Powlowski: I've talked enough, Dr. Grant.

It's hard for me, given what we're seeing with MAID, to really believe there will be oversight. Maybe you haven't seen the cases. Tell me what you can to reassure me there will be oversight.

Douglas Grant: The first thing is that the decisions of colleges are only made public and circulated to members when there's been a disciplinary finding. In the case of your example, a concern about clinical practice would only be circulated if there was a disciplinary finding.

In the brief amount of time allotted to me, I'll say that this speaks well of the many layers of regulation Dr. Close described. If you look at examples of medical assistance in dying in Nova Scotia, involved in that process would be nurses, nurse practitioners, social workers and two physicians of different disciplines. As employees of a health authority, each of those professionals would have responsibilities if they saw something amiss. They would have professional responsibilities, as physicians do under the CMA's code of ethics. They would have the professional standards of their regulatory body, or of other regulated health professions, to report it themselves if they witnessed something unprofessional. They would have duties as citizens: “When you see something, say something.” There are many layers of—

● (2000)

The Joint Vice-Chair (Hon. Pierre Dalphond): The question was very long, but unfortunately time is running out.

Douglas Grant: That's fair enough.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you.

[*Translation*]

We now go to Mrs. DeBellefeuille for four minutes and 15 seconds.

Claude DeBellefeuille: Thank you, Mr. Chair.

Ms. Close, your remarks were very compelling. You said that the job of lawmakers is to set legislative guidelines, but also to take a more holistic view. That means talking about the suffering people with mental illnesses are experiencing.

I'll never forget a schizophrenia client I had. They would come to see me and ask whether they could receive MAID. They experienced visual and auditory hallucinations and paranoid thoughts, and despite 25 years of treatment and medication, they couldn't live without suffering. For a variety of reasons, they couldn't see a future for themselves. They genuinely wanted to consent to an assisted death, but that isn't possible yet.

Don't you think it is also up to those practising the profession to examine and define suffering? Work in Canada to establish those guidelines is advancing slowly, but here, around the table, we aren't talking much about suffering. Even with professional support, some people continue to suffer and just can't do it anymore. Do you think we aren't focusing enough on the suffering dimension in this evening's debate?

[*English*]

Eliana Close: I think suffering is important. Of course, it's part of our Criminal Code and of our law. I'm obviously not a clinician, but the law tells us that individuals need to tell us that they're suffering.

While my research hasn't looked at the normative questions around MAID for mental illness as a sole underlying disorder, I know that the notion of suffering and the notion that some people who are suffering from a mental disorder may have intractable suffering and may still want an autonomous choice are rooted in our charter. That is why our court has decided that this is part of the law.

[*Translation*]

Claude DeBellefeuille: Dr. Grant, where do you stand on a case where the patient has an incurable mental illness, will suffer all their life and has tried everything, from therapy and drugs to professional treatment?

Should that patient be able to choose MAID to end their life after years of suffering?

[*English*]

Douglas Grant: I should probably limit my answer. My personal answer is yes, but my answer as a representative of the College of Physicians and Surgeons is that I have confidence in the medical profession's ability to discern whether that patient can provide informed consent for this.

[*Translation*]

Claude DeBellefeuille: You have confidence, then, in the medical professional's ability to help the patient make the free and informed decision that is right for them.

[*English*]

Douglas Grant: Very much so. To me, informed consent is the cornerstone of the Canadian medical system. Physicians are robustly trained to identify the decisional capacity of patients. We do it in many complicated scenarios, and this is one of them.

Physicians are also challenged in many disciplines to determine whether patients can provide informed consent. There is the mature 14-year-old who seeks or denies transfusion, the mature 13-year-old who seeks contraception, and the suffering patient who chooses not to pursue the potential life-saving treatment of chemotherapy. It's a regular feature of medicine—and of all health professions, by the way—to identify whether a patient has decisional capacity and can provide informed consent. I believe this should remain in the hands of medical professionals.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you, Dr. Grant.

Is there consent to go until 8:20 and then suspend for the vote?

Some hon. members: Agreed.

● (2005)

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you.

Now we'll move to the senators.

The Joint Chair (Marcus Powlowski): We have Senator Moodie for three minutes, please.

Hon. Rosemary Moodie: My first question is for Dr. Grant.

We have heard testimony from John Maher, who mentioned a case that he claimed he was aware of in which MAID was offered to a 30-year-old. He claimed that he called the college of Ontario on this, and they said something about the patient not being dead yet, so they couldn't do anything.

What would a physician do if they believed that another clinician was not complying with the Criminal Code provisions on MAID? What would your college, and I presume other colleges like yours, do if presented with an allegation that a clinician is operating in a way that has already breached the Criminal Code or is going to?

Douglas Grant: We'd investigate, and we'd investigate quickly.

At the risk of repeating what I said to the previous question, physicians have a duty to report. That's a professional standard all colleges have.

Physicians have a professional and ethical duty to report, which is embedded in the CMA code of ethics. Physicians working in health authorities have safe disclosure or whistle-blower responsibilities throughout, as do all other health professionals. I have a hard time envisaging a situation as described in the previous question where the regulator, the health authority and the other professionals involved are blinded to this unprofessional conduct.

The short answer to your question is that if we receive that phone call, we investigate immediately.

Hon. Rosemary Moodie: Thank you.

Dr. Close, this is a question for you. You've talked a lot about the importance of coal face regulation. Does that mean you expect there would be variability across the country? Does it strike you as a problem that coal face is an integral part of the complete package of oversight and regulation that you referred to?

Eliana Close: There is variation across the country. We are a federation. Ultimately, provinces and territories have made different decisions about how to invest in their MAID programs and how some of the coal face regulation operates.

I don't think variability is 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. Some provinces have very few cases of MAID. The very fact that there's variability should not be cause for concern on its own.

Hon. Rosemary Moodie: Thank you.

Do I have time, Mr. Chair?

The Joint Chair (Marcus Powlowski): You have 15 seconds.

Hon. Rosemary Moodie: Dr. Grant, are you aware of any cases in your college or in colleges across the country where MAID physicians have committed the crime that was described by John Maher in his past testimony?

Douglas Grant: I am aware of none, though I take note of the case in British Columbia referred to in the previous question.

Hon. Rosemary Moodie: Thank you.

The Joint Co-Chair (Marcus Powlowski): Thank you.

Senator Osler, you have three minutes, please.

Hon. F. Gigi Osler: Thank you, Chair, and thank you to all the witnesses.

My question is for Dr. Close.

Five minutes is a very short period of time, and you've tried to cover as much of your research and analysis as you could. Can you share with the committee if there are other key aspects of monitoring, oversight and regulation that you think are important for this committee to understand, particularly as they apply to MAID with mental illness as the sole underlying medical condition?

Eliana Close: Can I just clarify what you mean by other aspects?

Hon. F. Gigi Osler: Can you share with us anything else in terms of monitoring, oversight and regulation that you want us to know?

Eliana Close: Thank you.

One thing that I think gets underappreciated is that the existence of no escalation or no disciplinary consequences from the colleges gets used to suggest that they are looking the other way and that problems are not being detected. What is often happening, and what we know from the Ontario MAID review team data, is that tiered responses happen when matters go to regulators. Often, it's administrative errors that are occurring, and these are easily and quickly addressed by things like an educational email or a phone call. This type of tiered response is normal in regulation.

The Ontario review team data, which I can provide to the committee, also says that no MAID cases have been escalated to the police. Again, that gives me confidence that these mechanisms are working. It's not that things are being covered up. It's just that they're not occurring.

The tiered response mechanism is really important to know. When we're looking at the data, we need to look at those reports and see what is actually going on in practice.

● (2010)

Hon. F. Gigi Osler: Thank you.

Dr. Grant, can you respond to any of the implications that colleges are looking the other way or that cases are not being taken seriously?

Douglas Grant: All I can speak to is my own college.

We take them very seriously. I've had the benefit of working closely with Nova Scotia's MAID team in the development of their clinical standards. We have this device in Nova Scotia called “the phone”, and when there are difficult cases, I'm often phoned by clinicians who say, “Hey, Gus, how do you think we should proceed?”

I think Nova Scotia enjoys a very close relationship between the regulatory body, the health authority and the clinicians delivering the care, so I'd say just the opposite. We're not turning away. We're leaning into these cases, and I'm grateful to have the opportunity to do that.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Wells, you have three minutes.

Hon. Kristopher Wells: Thank you.

Dr. Close, this committee has heard from multiple witnesses that the current safeguards to protect against illegal MAID assessments have fallen short. Based on your research and the empirical evidence you referenced in this meeting, what recommendations do you have for any additional safeguards or other forms of regulation we should be considering for MI-SUMC?

Eliana Close: I don't think additional safeguards are warranted in the law. I think the system has enough safeguards.

What is needed is more transparency in provincial oversight. We have good data from, say, Ontario, which the coroner, I understand, will make publicly available from the MAID death review team. There need to be networks of accountability mechanisms, which exist already but can be reinforced. That requires investment from the provinces. Ultimately, that's a provincial decision.

These mechanisms are more flexible and appropriate for dealing with complex cases. They're not additional legislative safeguards.

Hon. Kristopher Wells: Thank you.

Dr. Crawford, suicidality is not uniquely associated with mental illness, as we've heard from previous experts. When your organization receives phone calls asking questions about MAID, how is your organization providing accurate and objective information to those callers?

Allison Crawford: Do you mean about MAID?

Hon. Kristopher Wells: Yes.

Allison Crawford: We do not. We have an explicit policy that we treat every instance as an opportunity for suicide prevention.

Hon. Kristopher Wells: Then you wouldn't refer them to any MAID-appropriate services.

Allison Crawford: No.

Hon. Kristopher Wells: Thank you for that.

Dr. Grant, at our last committee meeting, on April 21, one witness stated in their testimony that clinicians cannot be entrusted with the great power and responsibility of MAID MI-SUMC. How would you respond to that criticism?

Douglas Grant: It's hard to respond to it because I don't know the basis from which it comes. Clinicians are licensed with an extraordinary depth and range of responsibilities that involve life and death across a number of disciplines. I don't know why this is distinguishable.

Hon. Kristopher Wells: Just to re-emphasize what you said, regulators are ready and will enact this law should Parliament move forward.

Douglas Grant: We're awaiting instructions.

Hon. Kristopher Wells: Thank you.

The Joint Chair (Marcus Powlowski): Thank you.

We are back to the second round.

The Joint Vice-Chair (Hon. Pierre Dalphond): Mr. Lawton, you have two minutes and 33 seconds.

Andrew Lawton (Elgin—St. Thomas—London South, CPC): Dr. Grant, Senator Moodie asked you what you would do if allegations of criminal misconduct were referred to you. I want to confirm that I understood your answer to be that you would investigate them internally and not refer them to police. That is what you said twice.

Douglas Grant: If I did, I misspoke. If we have a concern that arises with us that is on its face criminal, we immediately phone the RCMP. We get it quite often in other domains of regulation. Typically, if there's merit to the concern, we'll apply interim sanctions if those are available to us—as in suspend the physician's licence—and then refer it to the RCMP or law enforcement.

● (2015)

Andrew Lawton: I'm relieved to hear that. Thank you.

Douglas Grant: I'm sorry if I misspoke.

Andrew Lawton: Dr. Close, just for clarity, you have a Ph.D. and not a medical doctorate. Is that correct?

Eliana Close: That's correct.

Andrew Lawton: I want to talk about the very important question of physician readiness. This is not from people on the outside of the system looking in. These are comments made by MAID assessors and practitioners in your own research.

Here's one: “We're not infallible. There are stupid clinicians. We need to make sure it's done well and oversight’s mandatory.”

Here's another one: “Maybe I've been doing things wrong for five years. I don't know”.

Here is another one: “I agree there's oversight on my ticky-boxes, but there's no oversight on the quality of my work.”

How do you rationalize your claim that there is robust oversight already when the practitioners cited in your own research would seem to contradict that thesis?

Eliana Close: It's important to take that research in its context. Those participants were talking about different oversight mechanisms and making more general comments.

With respect to the comment about not knowing if there's oversight on my “ticky-boxes”, that was specifically a comment on the lack of transparency in the British Columbia processes. I wholeheartedly support more transparency around that.

These comments were also illustrating that oversight shouldn't just be about following all the elements of the Criminal Code. Oversight should also be about continuous quality improvement and learning from mistakes. That is where there is a role in Canada that we see is there but could be bolstered.

Andrew Lawton: Thank you. I have only 10 more seconds.

You mentioned retroactive oversight. To be clear, that would be oversight when the patient is already dead. Is that correct?

Eliana Close: Retrospective, yes, is after the patient is dead.

Andrew Lawton: Thank you.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you.

Next and probably last before the break is Dr. Jaczek.

Hon. Helena Jaczek (Markham—Stouffville, Lib.): Thank you so much.

Thank you to the witnesses.

Dr. Close, you've talked about the regulation of MAID—guidelines, training and best practices. Would it be helpful, in a case in which the sole underlying condition is a mental illness, to have some sort of documentation?

In Ontario, I believe there are clinician aides essentially documenting that a clinician has gone through a whole series of questions around the reason for the request for MAID. In other words, in the case of mental illness, it's documentation that says so many treatments had been provided, with details and so on, and were not successful. I'm thinking of the chronic schizophrenic who has tried everything, including electroshock. Would it be helpful to have a uniform assessment tool, in writing or digital, that would be available for review?

Eliana Close: Regulatory design and system design are important parts of regulation. Forms can help clinicians know that they are going through the required steps they should be going through.

I don't think there could be a form that could say, “You must go through and try five different treatments before this is allowed.” That would be overly prescriptive, but the form itself can be a way of translating legislative safeguards or other best practices so that clinicians are going through those steps.

Hon. Helena Jaczek: Dr. Grant, do you in Nova Scotia, as a college, have any requirements for very specific steps that under the current situation with MAID a clinician is required to go through?

Douglas Grant: Our professional standard, which is on our website and available to the public and the profession, is very prescriptive. It's quite step-by-step. It very much aligns with all of the legislation in the Carter decision, and it's the foundation for the clinical protocols in place at the Nova Scotia Health Authority. Ours is just the professional standard.

Hon. Helena Jaczek: You would create such a standard for the sole underlying condition of mental illness.

Douglas Grant: I'm certain that we would adapt the one we have in place.

Hon. Helena Jaczek: I have no further questions.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much.

We're going to suspend for the vote in the House of Commons.

Witnesses, please stay and stand by, because we're going to resume after the vote in about 15 or 20 minutes from now.

Thank you very much. I'm sorry for the interruption.

● (2015)

_____(Pause)_____

● (2105)

The Joint Vice-Chair (Hon. Pierre Dalphond): We're resuming.

Thank you very much to all those who have been waiting patiently for this panel and the next. There was a vote and we had to suspend.

There are only three questioners left for this panel.

Madame DeBellefeuille, go ahead, please.

[*Translation*]

Claude DeBellefeuille: Thank you, Mr. Chair.

Dr. Grant, you said that if lawmakers decided to expand MAID eligibility to people with mental illnesses, Nova Scotia would be ready.

If we decided to recommend expanding MAID access, would you be worried that it would encourage people in Nova Scotia to end their lives?

● (2110)

[*English*]

Douglas Grant: No, I would not be worried about that, but I'm not a clinician working in that space. I would be confident that the assessment for eligibility for MAID would be done in a reasoned way.

As we were saying during the break, a patient whose sole underlying medical condition is a mental disorder is not a patient who's being assessed for MAID at three in the morning by an emergency department physician. That assessment is being made over time by two separate clinicians after there's been a demonstration of enduring suffering and marked decline.

No, I would not be worried about that.

[*Translation*]

Hon. Pierre Dalphond: Thank you.

[*English*]

The Joint Chair (Marcus Powlowski): Senator Moodie, you have one minute and 42 seconds.

Hon. Rosemary Moodie: Thank you, Chair.

Dr. Grant, would your college look to guidance documents from professional associations when setting your own practice standards and assessing a clinician's practice?

Douglas Grant: Absolutely. When we developed our professional standard on MAID initially—it's been edited a number of times over the years as the law has changed—we started with the decision in Carter. Then we looked at Bill C-14 and Bill C-7. We had consultation with the CMPA, the CMA and various stakeholders throughout the space. The beauty of being in a small province like Nova Scotia is that I've had the benefit of working closely with the clinical team and the administrative team that oversees the delivery of medical assistance in dying.

It's very much a collaborative effort.

Hon. Rosemary Moodie: I know that you meet with your colleagues in other colleges from time to time. When you meet with your colleagues from the other regulatory colleges across Canada, does MAID practice stand out as an area of poor practice, with unethical and unprofessional practices being common?

Douglas Grant: I'm sorry. I didn't hear what you said.

Hon. Rosemary Moodie: When you meet with your colleagues, are you talking about MAID practice standing out as an area of poor practice, with unethical concerns in professional practices?

Douglas Grant: No. Quite frankly, it's the opposite. It's an area where really passionate physicians are drawn to work.

Hon. Rosemary Moodie: Thank you.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Osler has the floor for one minute and 42 seconds.

Hon. F. Gigi Osler: Thank you, Chair.

Dr. Grant, this committee has heard very different pictures of the safety of MAID practice from a regulatory point of view. How do you as a regulator reconcile these very divergent views?

Douglas Grant: Well, it's hard to answer to anecdotes that I know nothing about. As I was saying earlier, there's an arithmetic of compassion. One extraordinary story can have an enormous influence against thousands of other cases. MAID, in the context of all the medicine that's being delivered and the ever-changing, progressive changes in medicine, is extraordinarily regulated and monitored.

I really do admire the testimony given by Dr. Close earlier. I hope the committee appreciates the levels of this matrix of regulation that takes place, from the coal face all the way up to the regulator's desk.

Hon. F. Gigi Osler: Thank you, Dr. Grant.

Thank you, Chair.

The Joint Vice-Chair (Hon. Pierre Dalphond): That completes the second panel.

On behalf of the committee to all members of the panel, thank you very much.

We'll suspend for a few minutes to bring on the third panel.

Douglas Grant: Chair, if I may speak, at the beginning, you introduced me as speaking on behalf of the Federation of Medical Regulatory Authorities of Canada. I was invited as the registrar of the College of Physicians and Surgeons of Nova Scotia only.

● (2115)

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much.

We are suspended.

● (2115)

_____(Pause)_____

● (2115)

The Joint Vice-Chair (Hon. Pierre Dalphond): I wish to welcome our witnesses who are with us tonight for our third and last panel for today.

Appearing as individuals, we have Dr. Jitender Sareen, head of psychiatry and professor in the department of psychiatry at the University of Manitoba, and Dr. Sandip Singh Gandham, assistant clinical professor in the department of family medicine at the University of Alberta. Representing the Ontario Hospital Association, we have Melissa Prokopy, vice-president of policy and advocacy, and Dr. Kevin Young, vice-president of medical affairs.

Dr. Sareen, you have five minutes.

Jitender Sareen (Head of Psychiatry and Professor, Department of Psychiatry, University of Manitoba, As an Individual): Thank you, Chair and members of the committee, for the invitation to appear today.

My name is Dr. Jitender Sareen. I am speaking as department head of psychiatry at the University of Manitoba and as a provincial specialty lead for mental health and addictions at Shared Health. I have practised adult psychiatry for more than 25 years. My perspective today reflects my clinical, research and system experience, rather than a philosophical or conscientious objection to MAID itself.

MAID for mental disorders has been a difficult issue in Canada, and there are thoughtful perspectives on both sides. I respect concerns about autonomy and suffering associated with mental disorders. However, after a careful, unbiased review of the international literature, I believe Canada should not expand MAID to include mental disorders as a sole underlying condition.

First, prognosis in mental disorders is often uncertain. Individuals can remain severely ill for long periods and still improve, particularly with changes in treatment and psychosocial situation. There is no international standard that defines irremediability in mental disorders. When you're regulating something, unless you have an international standard to hold somebody accountable, you cannot regulate it.

Second, there is also no clear and reliable way to distinguish a request for MAID from suicidality when mental disorder is the sole underlying condition. Unlike physical conditions, suicidal ideation is part of the diagnostic criteria for many mental disorders, including depression, post-traumatic stress disorder and borderline personality disorder. This goes to the core psychiatric practice, which is grounded in assessing and treating hopelessness and preventing suicide.

I know you have been reassured by some other witnesses that psychiatrists are trained to make distinctions between MAID and suicide, but psychiatrists and psychiatry residents nationwide are not being taught how to distinguish MAID from suicidality, because there's simply no way to do it. Most academic chairs of psychiatry departments across Canada have similarly recommended against the expansion of MAID because of these concerns.

Third, most international professional associations and people with lived experience groups have clearly recommended against providing MAID for mental disorders. In 2025, the American Psychiatric Association's position paper explicitly opposed this, citing the difficulty in defining irremediability, the unpredictability of prognosis and the concern that mental disorders themselves may influence decision-making. The International Association for Suicide Prevention has also expressed opposition to MAID.

In Canada, both the Canadian Association for Suicide Prevention and the Canadian Mental Health Association have raised concerns about expansion, alongside organizations representing people with lived experience and disability advocates, such as Inclusion Canada and Indigenous Disability Canada.

In 2023, Quebec passed Bill 11, which established that a mental disorder other than a neurocognitive disorder cannot be an illness for which a person may request MAID. This year, Alberta has proposed Bill 18 to exclude MAID for mental illness and to restrict access to MAID to individuals with a foreseeable death in the next 12 months.

As for Manitoba, when this issue was brought to our provincial psychiatry leadership council in 2022, and again in 2026 in the context of operational planning, the council reached a clear consensus on both occasions that expansion to mental disorders should not proceed.

For these reasons, I respectfully urge this committee to recommend an indefinite pause on the expansion of MAID for mental disorders.

Thank you.

● (2120)

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much.

Now we'll go to Dr. Gandham.

Sandip Singh Gandham (Assistant Clinical Professor, Department of Family Medicine, University of Alberta, As an Individual): Honourable Chairs, thank you for inviting me to appear before you today. I appear before you as an individual.

I'm a family physician with experience working in addictions medicine, mental health and end-of-life care. My perspectives are shaped by providing care for those with profound suffering, including an expressed wish to die. I've also worked as a MAID assessor and provider since 2016. I come to the discussion not as an ideologue, but as a clinician who has sat with suffering in many forms—physical, mental, existential and social.

I want to begin by acknowledging something very important. Suffering associated with severe mental disorders can be unbearable. Those of us who provide care for those with severe chronic mental illness know this first-hand. Their suffering is real. It is not less real because it is psychiatric rather than physical.

Recognizing 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.

There's also an argument rooted in compassion. For a small subset of people whose suffering may truly be enduring, refractory and intolerable despite years of care, MAID may be seen as a last resort to relieve their suffering where other medicine has failed to relieve them.

Those arguments deserve serious consideration, but so too do the risks. In my view and from my clinical experience, the risks of proceeding currently outweigh the potential benefits. These risks are not just incidental; they're fundamental.

It begins with the concept of irremediability. In many physical illnesses where MAID is currently provided, prognosis may be difficult, but it is often more knowable. In psychiatry, by contrast, predicting that a person's suffering is truly irremediable is far from certain.

Recovery in mental illness can be non-linear and surprising. Patients who at one point seemed like they were beyond hope may later improve from treatment, sometimes because their circumstances change—housing stabilizes, trauma is addressed, substance use remits, relationships repair or hope returns—and sometimes simply from the passage of time itself. I've seen patients who had once believed death was their only relief find stability, meaning and reasons to live later. That uncertainty matters deeply when the intervention being considered is irreversible.

A second concern is that many features of severe mental illness can directly affect the wish to die. Hopelessness, self-destructive thinking, impaired future orientation, and suicidality can all be symptoms of the illness itself. Particularly in addictions medicine, I see how suffering can distort what appears to be a settled wish for death. Distinguishing a sustained, autonomous wish to die from a treatable expression of an illness is not a simple assessment challenge. It is often the core clinical question.

I 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. That is not a distinction we can afford to get wrong.

My third concern is that I'm deeply concerned about structural vulnerabilities. Requests for death don't arise in a vacuum. They may emerge in the context of trauma, poverty, isolation, inadequate housing, long ways for treatment, and lack of access to care and supports. If people seek MAID because they cannot access the conditions necessary to live with dignity, that is not a triumph of autonomy; it is a failure of care. In such cases, the suffering may be real, but its drivers may be remediable through social response rather than death as a medical intervention.

That raises a profound ethical concern: Are we offering MAID in some cases because a person's suffering is truly irremediable or because our systems have been unable or unwilling to provide what people need to live? I would submit that Canada has not yet demonstrated a mental health and social care system robust enough to assure those alternatives are meaningfully available.

Some may still argue that this is discriminatory. I would respectfully suggest caution is not discrimination when it arises from genuine clinical uncertainty and concern for protection of the vulnerable. Equal respect does not always require identical responses when the underlying clinical realities differ.

For me, the question is not whether some people with mental illness suffer grievously—they do. The question is whether we can reliably distinguish in practice those rare cases where suffering is truly irremediable from those where despair may yet be treatable. I am not persuaded we can do so with sufficient confidence.

● (2125)

Where doubt exists in matters of life and death, where prognosis is uncertain and where vulnerability is profound, caution is not paternalism. It is an ethical responsibility.

Thank you.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much.

We'll go now to Ms. Prokopy.

Melissa Prokopy (Vice-President, Policy and Advocacy, Ontario Hospital Association): Good evening, Mr. Chair. Thank you so much for today's invitation.

I am Melissa Prokopy. I'm the vice-president of policy and advocacy at the Ontario Hospital Association. The OHA represents Ontario's 135 hospitals. Our membership includes a diverse representation of hospitals of various types and sizes, including mental health and addictions hospitals. I'm joined today by Dr. Kevin Young, who's the vice-president of medical affairs and chief of staff at the Waypoint Centre for Mental Health Care in Penetanguishene, Ontario.

Today, we'll share with you perspectives from the hospital sector about the Ontario health care system's readiness for the proposed expansion of MAID where mental illness is the sole underlying medical condition.

I want to outline three key concerns we have heard from our hospital members with respect to the proposed expansion: existing challenges to access to mental health care services more broadly, the impact of inequities in accessing these services by different parts of the population, and broader system readiness by health care providers to deliver MAID.

I'm going to ask Dr. Young to outline these access and equity points in more detail.

Kevin Young (Vice-President, Medical Affairs, and Chief of Staff, Waypoint Centre for Mental Health Care, Ontario Hospital Association): Thank you, Melissa.

With respect to access to mental health care services, there are still significant barriers in Ontario and across Canada. Recent data from the Canadian Institute for Health Information reveals that 41% of adults aged 18 or older who were diagnosed with mental health disorders say that their needs were only partially met or were completely unmet. These challenges are relevant not just on a patient level but also when looking at overall system readiness.

For example, in 2024, the OHA commissioned a study with the University of Toronto that examined the expected impact of chronic illness on the health care system in the next 20 years. Mood and anxiety disorders and substance use disorders were noted to be contributing to the rise in chronic disease among young Canadians. This means additional strain on the health system and an increased need for improved access to mental health care.

Additionally, we heard that existing challenges to accessing care can complicate the provision of MAID. They also present challenges for health care providers in eligibility assessments. Health care providers must be assured that MAID is not chosen by patients simply because they cannot access necessary mental health care.

Clinical challenges caused by inadequate access to mental health care can cause further system impacts. For example, a patient might be found to be ineligible for MAID but continue to have issues accessing mental health supports. Practitioners may be required to address access issues in the MAID application process through facilitating consultations or seeking expedited treatment for applicants, which may be the best course of action for a particular patient, but this could also create the risk that the process becomes a means to access mental health care more quickly, which can then further increase inequities in accessing care.

It's also important to consider equity in access to mental health care. As we know, systemic inequalities such as racism, poverty, homelessness and others can worsen mental health. For example, Statistics Canada reported in 2024 that among indigenous people who required or were seeking mental health care, the vast majority—approximately three-quarters—reported that their needs were unmet or partially met.

The federal government recognizes the significant barriers facing indigenous people in accessing mental health supports. These barriers are rooted in systemic racism, geographic location and other structural factors. Past consultation by the federal government with indigenous people on MAID underscored the need to improve access to mental health services and the need for further consultation on MAID expansion.

Enhancing access to mental health care would help ensure that MAID is truly informed and a voluntary choice. We believe that additional consultations should continue before the government makes any decisions to move forward with an expansion.

I'll hand it back to Melissa now for some more information about system capacity challenges.

● (2130)

Melissa Prokopy: Thank you, Dr. Young.

Our final point is that hospitals have identified clinical gaps that constrain system capacity. For example, we have heard that there is still no clear agreement among clinicians about determining eligibility for MAID where mental illness is the sole medical condition. This includes how to decide whether mental illness cannot be treated and how to tell the difference between a MAID request and suicidal intent.

Further, we've heard about the need for clear clinical guidance and training to ensure providers feel well prepared. One of our members, the Centre for Addiction and Mental Health in Toronto, has publicly recommended that guidelines must be consensus-based, given that there is a lack of evidence on this issue.

For these reasons, we believe that more time is needed to develop consensus and ensure system capacity and preparedness.

Thank you again for the opportunity to speak to the committee. We're happy to answer any questions you might have.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much for your presentations.

We have agreed to go for only one round, because we're running a bit late. The interpreters are also running late, but they're staying. Each MP will have five minutes or can share their time with another colleague. Senators will each have three minutes.

Mr. Lawton.

Andrew Lawton: Thank you very much, Mr. Chair.

Thank you to the witnesses.

As a matter of context, Dr. Gandham, you are a MAID assessor and provider. Is that correct?

Sandip Singh Gandham: That's correct.

Andrew Lawton: When you come at your position of skepticism, it's not coming at all from anywhere near a conscientious objection to MAID itself.

Sandip Singh Gandham: Definitely not.

Andrew Lawton: Okay. I appreciate that very much.

You've done events with Dying with Dignity Canada. Is that right?

Sandip Singh Gandham: I have done that.

Andrew Lawton: Thank you for that.

I'd like to move to our witnesses from the Ontario Hospital Association. This is for whoever would like to take it.

We heard earlier from a witness—who was for the expansion of MAID to people with mental illness—that if individual practitioners don't feel ready, they should simply not be part of the MAID regime. For your member hospitals dealing with the same dissent that we've seen among witnesses on this committee, how could a hospital even begin to move forward with this when there is no consensus among the psychiatric community and no consensus even among the MAID assessment community?

● (2135)

Melissa Prokopy: I'm happy to start. Kevin may have something to add as well.

I will reinforce the point I made, which the Centre for Addiction and Mental Health has stated quite publicly, that we need consensus. Part of the OHA's role in supporting 135 institutions across Ontario is to create, from an organizational perspective, a standard and consistent approach to how we navigate access to any service. Given the lack of clinical consensus across the board on MAID at an individual level, we think the focus at this point in time should really be on broader access to mental health services across the health care continuum.

Andrew Lawton: I know the system has accounted for individual physicians who don't want to participate in MAID, but at an institution level, if the expansion does go forward, are you convinced that hospitals would have the adequate legal grounds to say that they will not participate because they do not feel ready to offer this, specifically referring to MAID for people with mental illness?

Melissa Prokopy: I'll just clarify that the OHA is not a regulatory body. We're an association. Certainly, we represent all the hospitals. We're aware that a number of our hospitals are faith-based institutions. We also know that members are committed to respecting patient choice and providing effective, evidence-based consultations for MAID. Our job is really to support those efforts within the organizations.

Individual organizations make individual choices. Really, from our perspective, our role is to help create a consistent, standardized approach as much as we can.

Andrew Lawton: Thank you.

I'll cede to Mr. Cooper.

Michael Cooper: Dr. Gandham, I just want to confirm that you are the provincial medical lead for MAID for Alberta Health Services and have been in that role since 2019.

Sandip Singh Gandham: I am, but I am here as an individual. I'm not representing them.

Michael Cooper: Thank you.

Dr. Sareen, in your professional opinion, does the CPA guidance have evidence of readiness for the expansion of MAID for mental illness?

Jitender Sareen: I've reviewed the CPA MAID guidance document. On the front page, it says it has not been peer-reviewed. I'll stop there.

I will add that the CPA says on their website that they don't have a position on MAID. You've heard testimony from a number of people saying that there's no international definition around irremediability and differentiating MAID from suicide. That guidance document is not peer-reviewed. It's from a small group of people.

Michael Cooper: You were not consulted.

Jitender Sareen: No.

Michael Cooper: Are you aware of other heads of psychiatry being consulted?

Jitender Sareen: No.

Michael Cooper: It copies and pastes Health Canada's model practice standard with respect to irremediability. Do you see that as appropriate criteria, or is that problematic?

Jitender Sareen: No, I don't see it as appropriate criteria. That's what the chairs of psychiatry have also submitted—a briefing to this committee saying that they don't support expansion.

Michael Cooper: Would you agree that you can look at past treatments, but the most important question is what is going to happen in the future? That's something that the practice standard criteria do not address.

Jitender Sareen: Exactly.

Michael Cooper: What about on the question of suicidality? We heard testimony from the head of chairs of psychiatry that it actually creates clinical confusion. Would you concur?

Jitender Sareen: Yes, I agree.

I'll repeat that the CPA guidance document has not been peer-reviewed. Internationally, the document that I've referenced—the American Psychiatric Association document—has been peer-reviewed and approved by the APA board and the International Association for Suicide Prevention research as well.

I don't support the document from the CPA.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you.

[*Translation*]

We now go to Mr. Fergus for five minutes.

Hon. Greg Fergus (Hull—Aylmer, Lib.): Thank you, Senator.

First, I want to thank our witnesses for being with us today to share their views and speak to the committee about a very sensitive issue.

I'm brand new to the committee, and in the little testimony I've heard so far, one of the things that's come through is the lack of consensus. Some health professionals are saying that they're ready, that the rules and guidelines are in place, whereas others are telling us that they aren't ready. Some are saying they have the capacity to provide the service, while others are saying they don't.

Dr. Gandham, I very much appreciate that you recognize the gravity of mental illness and what a very serious condition it is for some Canadians. I also appreciate how candid you were, explaining that while the issue deserves serious consideration, you personally believe we still aren't ready and you don't agree with moving forward.

I want to step back a bit and ask all of you this question: Regardless of our capacity to handle these requests or develop guidelines to ensure that the process is carried out properly, do you think Canadians are ready for MAID in this context?

You can go first, Dr. Gandham.

● (2140)

[*English*]

Sandip Singh Gandham: I wonder, in this case, if we're putting the cart before the horse. When we look at any sort of illness, when you want to treat it, you have to look at the root cause. That's what we're taught. If you really want to cure it, you have to look at the root cause. When you look at mental illness, it's not something that just arrives out of the sky. There are lots of deep, complex, intertwined causes for it.

Working in addictions for the last seven to eight years, I've yet to see somebody with severe substance use disorder who did not have some very difficult, traumatic childhood experiences or adverse childhood events, to varying degrees. They impact your ability to cope—your coping mechanisms and all that.

When we're talking about readiness, I think before our treatments...we're probably not even there.

[*Translation*]

Hon. Greg Fergus: Excuse me, Dr. Gandham. I'm not asking whether health professionals are ready. I'm asking whether you think Canadians at large are ready to accept this change.

[*English*]

Sandip Singh Gandham: It's hard for me to answer. I can't answer for the population and if they're ready. It depends on from what perspective. If the question is whether the majority feels this is appropriately ready and this is the right thing to do, in that sense, it would be hard to say.

I don't want to speak for the majority. I have my own, individual opinion, but if they knew the full facts, I do not think they would be ready.

[*Translation*]

Hon. Greg Fergus: Can you provide a brief answer, Dr. Sareen?

[*English*]

Jitender Sareen: The Canadian Mental Health Association, the Canadian Association for Suicide Prevention and Inclusion Canada all have said that we're not ready for MAID for mental illness. They've said that publicly.

It can be theoretically thought about, but in reality, to make it available in Canada...you can't differentiate MAID from suicide.

Hon. Greg Fergus: I'm going to ask this of you, Ms. Prokopy and Dr. Young, very quickly because I have only about 30 seconds for both of you. Do you think your neighbours are ready? I have to sell this at the doors. Do you think the people you meet every day and talk to at the grocery store are ready for this?

Kevin Young: I can't speak for my neighbour, of course, but I can tell you that the members we heard from, from our hospitals, feel very strongly that they have a duty of care to have guidelines that are consensus-based, to know how to apply these things and to know that people have equitable access to care and are able to get the mental health care they need. In the absence of those things, people feel like they're not able to provide that service knowing that all of those gaps exist. That's important to consider.

The Canadian public would want to know that the people who are providing that care feel secure in their ability to do so and that the necessary infrastructure is there for them to do that.

● (2145)

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you, Dr. Young.

[*Translation*]

We now go to Mrs. DeBellefeuille for five minutes.

Claude DeBellefeuille: Thank you, Mr. Chair.

Dr. Sareen, I don't think there's a consensus on expanding MAID access to those whose sole medical condition is a mental illness. Nevertheless, there seems to be a consensus around the table, as well as in each province, about the lack of mental health services and supports. To fix that, the federal government has to increase its transfers to the provinces, which struggle to fund the necessary services.

The fact remains that people suffering from an enduring and incurable mental illness should have the right or freedom to make their own choices, live independently and, above all, live in dignity. They should be able to make the same choice those suffering from a chronic illness can.

What I want you to understand is this: In my view, people with an enduring and incurable mental illness who have received years of care and have the necessary support and services should also have the right to make their own decision in the end, to make a free and informed choice about what happens to them.

Dr. Gandham, in your practice, have you come across a patient with a mental illness who had no other way to end their suffering, so you would understand why that person would want to avail themselves of MAID and you would grant their request?

[*English*]

Jitender Sareen: As I said in my statement and as the American Psychiatric Association position paper states, in the moment, with regard to whether it's suicidal ideation or a MAID request, a clinician cannot differentiate whether this is part of a person's mental health or a psychosocial issue. You can have 100 treatments for years before, but that doesn't tell you what's going to happen in the future. That is very important.

As others have stated, the majority of Canadians don't have access to appropriate, evidence-based psychotherapy.

[*Translation*]

Claude DeBellefeuille: Sorry to interrupt, Dr. Sareen, but I know that not everyone in Quebec or the other provinces has equal access to the same care. However, I think that someone with an enduring and incurable mental illness has the right to choose what's right for them. We've got two types of patients, and we're discriminating against one of them. That's how I see it.

I agree that there isn't a consensus and that this may not be the right time to expand MAID eligibility to people with a mental illness, but we need to get ready. People with an enduring and incurable mental illness are going to ask for MAID, and we need to be able to alleviate their suffering.

Dr. Gandham, what are you doing to advance your thinking on the issue and move towards clinical readiness, since this decision is probably coming at some point? What are you doing to get ready for the clinical decision to provide this care to people with an enduring and incurable mental illness?

[*English*]

Sandip Singh Gandham: What have I been doing? I think my position over the last eight or nine years working in addictions has changed. It's evolved. I am still a supporter of MAID, and I do it regularly.

The premise here that we have to look at is about what's incurable. What are we basing that on? What is the standard definition we have for “treatment resistance”, which is often used—treatment-resistant to what? Treatments have been offered. Is that enough? Were they culturally specific? Were they trauma-informed? You have individuals who have all these issues, and they're not going to engage....

Dr. Neufeld, a couple of days ago, talked about the therapeutic alliance. Just because something is offered.... If there's no connection, where is the person in their trajectory? Are they pre-contemplative or contemplative? Do they believe in it? All those factors are known. Research shows whether a treatment would work or not. Are we accounting for all that?

When we look at any treatment, to be treatment-resistant.... We talk about a biopsychosocial treatment for all psychiatric issues. Yes, we give biological medications, but are people actually following them? Are they compliant and adhering to them? For psychological therapy, do people have funding to get that therapy? Do they actually access it? If they're single parents, do they have the money for it and do they have the time for it?

The final part is social. That's usually a little footnote. If you look at most of the psychiatric assessments—it's not because they're faulty; everybody is intentional—you see that those are out of the grasp of the psychiatrist or the treating physician. In many of those cases are the fundamental routes for many of these ailments. We're saying they're incurable, but we haven't given equal time, effort and resources to the biopsychosocial side, so how can we say they're incurable?

● (2150)

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you, Dr. Gandham.

The Joint Chair (Marcus Powlowski): We have Senator Moodie for her last three minutes.

Hon. Rosemary Moodie: Thank you, Mr. Chair.

I'm sorry. I can't get my camera on, but I will ask my questions.

I would just point out to Mr. Fergus that a 2023 Ipsos survey showed that support for MI-SUMC was 80%.

My question is for Ms. Prokopy.

Andrew Lawton: I have a point of order.

The Joint Chair (Marcus Powlowski): Mr. Lawton.

Andrew Lawton: I don't believe it's permitted for members to intervene with their cameras off.

The Joint Chair (Marcus Powlowski): I'm sorry, Senator Moodie, but you're required to have your camera on.

Hon. Rosemary Moodie: I'm trying my best. I keep clicking it.

The Joint Chair (Marcus Powlowski): Could we maybe go on to the next senator? We'll try to get IT to sort that out in the meantime.

Hon. Rosemary Moodie: Will I have the opportunity to ask my question?

The Joint Chair (Marcus Powlowski): Oh, there you are.

Go ahead. You have until three minutes from now.

Hon. Rosemary Moodie: Thank you.

My question for Ms. Prokopy is this. Are all the services deemed to be necessary or even essential for Canadians and for Ontarians available at all hospitals across Ontario? Is it not a fact that we have gone through, in the past 20 years, a process of regionalizing care so that certain hubs across the city have certain levels of care that are not available at every hospital, and selected services are not available at every hospital because of resource problems, because of critical-mass issues, because of available expertise and for other reasons?

Can you explain how this reality is not a problem for some of these essential services for Ontarians, but for mental health you would not see care become available, particularly care around MAID, because you perceive that all hospitals should have it equally?

Melissa Prokopy: I'll start by reiterating what I said earlier, which is a point you alluded to. Our concerns are around broader access to mental health care across the province. We have seen the emergency department visits for mental health increase by 11% in the last five to six years. We track something in Ontario called “alternate level of care” patients. These are patients who are waiting to be discharged from hospital to go somewhere else—to go home, to go to long-term care—

Hon. Rosemary Moodie: I'm sorry, but the question is about whether you see some sort of comparison between the fact that many services that we still offer in Ontario are not available across every hospital. We actually rationalize that care in certain places and don't offer it in every hospital. Is that a problem? Why is it such a big problem for us to not have MAID in every hospital to the same degree, to the same level? Why is that going to stand in the way of making this service available to Ontarians and to Canadians?

Melissa Prokopy: If I understand your question, I would say that not every service is available in every hospital. We have regional programs in Ontario—

Hon. Rosemary Moodie: That's correct.

Melissa Prokopy: —for cancer. We have localized programs—

Hon. Rosemary Moodie: That's my point.

Melissa Prokopy: Again, it depends on where you live in the province, it depends on geography, it depends on rurality and it depends on the complement or composition of the physician and nurse practitioner groups. That will determine the services you receive. That is the case across any service, not just in the context of MAID.

Hon. Rosemary Moodie: In the context of MAID, why is it necessary, before we proceed, to have equal levels of service and access across the system for your group to feel comfortable that this is something we can only then proceed with?

The Joint Chair (Marcus Powlowski): Please answer very briefly.

Melissa Prokopy: I would just say, to the comments the panel has made, that if there is no access to mental health services, housing, other community-based services and the treatments that the doctors on the panel today have described, how do we know that a person's underlying mental illness is irremediable? We need access to mental health services to be in place, and consensus among clinicians, before we get to a point where medical assistance in dying for mental illness will be collectively accepted, but that's a lot of conditions.

● (2155)

The Joint Chair (Marcus Powlowski): Thank you.

Next is Senator Osler for three minutes.

Hon. F. Gigi Osler: Thank you, Chair.

My question is for the Ontario Hospital Association. It's a bit of a follow-up to the last question, on access to care.

As you note, access to care and health care administration and delivery are primarily a provincial responsibility. What actions have the OHA taken with the Ontario government to resolve these issues in order to be ready for the lifting of the mental illness exclusion?

Melissa Prokopy: Maybe I can speak quickly at a high level and then ask Dr. Young to speak to some specific examples.

Part of the OHA's role as an association is to represent the voice of the hospitals of Ontario. We do that by working closely with the provincial government to not just expand access to hospital-based mental health services but also ensure that hospitals are working closely with primary care, community mental health, long-term care and home care so that people can have access to the services they need in the location they need it.

There are certainly significant gaps, as Dr. Young and I have both alluded to. We don't have access to care that's equitable across communities. We also know that there are certain populations that face inequities in a much greater way than others.

Kevin Young: I would add that we find that a lot of people come to the emergency departments and to hospitals because they're not able to access care in the community. This type of care is care that needs to be offered on a continuous basis over a longer period of time. Not having access in the community has been a big barrier.

The Ontario Hospital Association, together with many hospitals across the province, has been a very strong advocate of increasing home care and home care access for those with mental health, and of trying to increase access in the community to various types of treatment, including cognitive behavioural therapy, as well as rTMS and ECT. Despite all that, although we've made gains, we still fall well behind what we think would be a reasonable amount of care that's available equitably across the province.

Hon. F. Gigi Osler: Thank you for that.

I have two quick follow-up questions.

First, in 2016, when Bill C-14 became law, was there consensus on MAID? You did talk about needing consensus.

Second, in 2021, when MAID became legal for those whose natural death was not reasonably foreseeable, was there consensus?

Melissa Prokopy: There was certainly more consensus than there is now. We work closely with colleges, the government—

Hon. F. Gigi Osler: Was that in 2016 or 2021?

Melissa Prokopy: It was both.

Our objective is to create a framework to allow organizations to adapt in their specific circumstances. As I alluded to earlier, a number of our members are faith-based organizations. They have worked through their own challenges to encourage and promote access and patient choice. It hasn't always been easy, but certainly we've worked collectively as a group to try to make that accessible in ways that not only meet the needs of the patient, but also recognize some of the access and equity challenges the sector is facing.

The Joint Chair (Marcus Powlowski): Thank you, Ms. Prokopy.

We'll go to Senator Wells for the last three minutes.

Hon. Kristopher Wells: Thank you, Chair.

Dr. Sareen, you said that without an international standard, we cannot regulate the extension of MAID for MI-SUMC. However, multiple jurisdictions offer MAID in some form for persons with a mental illness. For example, the Netherlands uses the concept of “due care” as a base standard, with the assurance that a person is competent and conscious. This is the same in Belgium and Luxembourg. Spain and Colombia have developed other standards.

Why would these standards not be considered acceptable for us in Canada to use as guidance should this committee decide to extend MAID for MI-SUMC? What do these jurisdictions have that Canada does not have?

Jitender Sareen: Thank you for your question.

It's very important to remember that very few countries have allowed that. If you look at the data very carefully and look at the legal framework in Netherlands, you see that a person still has to go through a number of treatments. The provider can actually stop. That's one part that's not in the Canadian legislation. In Canada, you can think about the options as far as treatments go, but you don't have to go through them, and there have been significant concerns internationally about people dying in some of those countries.

Again, internationally, the International Association for Suicide Prevention, the American Psychiatric Association and the vast majority of countries in the world do not allow MAID for mental illness.

● (2200)

Hon. Kristopher Wells: If I could follow up, the countries I mentioned do, in some forms. Do you not think there are important lessons that we could learn here in Canada, should an extension be lifted, to provide those safeguards and have those regulatory processes in place? I'm saying that we have lessons to learn from. Why can't we apply some of those here in Canada?

Jitender Sareen: I think that's why in 2025 the American Psychiatric Association had a position paper on this issue, and the International Academy of Suicide Research.

Legally, Canada is one of the outliers among countries that allow MAID, with people having to only consider treatment options rather than go through them. That is a big difference that has already been an issue in Canada, but if you allow that for MAID for mental illness, it goes back to differentiating MAID from suicide and mental disorders.

Again, consensus on this topic is not there, and the international guidelines really do not support it.

The Joint Vice-Chair (Hon. Pierre Dalphond): Thank you very much, members of the panel. I know we kept you waiting for longer than expected, but you can be assured that it is quite appreciated.

I wish to thank our witnesses, the interpretation team, all of the staff assisting us tonight and all of you for your collaboration. Thanks to the collaboration of all, we were able to make it, despite some adjustments.

Tomorrow night, we're not sitting in this room. We're sitting in the floor below, in room 025-B here in the West Block. Make sure you come to the right place.

I now declare this meeting adjourned.