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# Special Joint Committee on Medical Assistance in Dying

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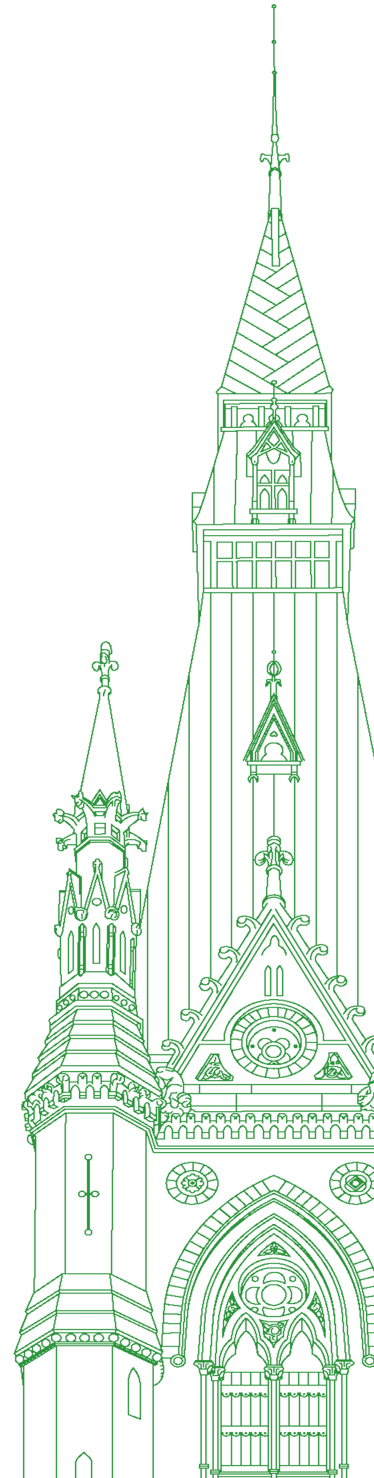

Co-Chairs: Marcus PowlowskiYonah Martin

# Special Joint Committee on Medical Assistance in Dying

**Tuesday, April 28, 2026**

● (1830)

[*English*]

**The Joint Chair (Marcus Powlowski (Thunder Bay—Rainy River, Lib.)):** I call this meeting to order.

Welcome to meeting six of the Special Joint Committee on Medical Assistance in Dying.

Pursuant to the order of reference of the Senate chamber adopted on February 26, 2026, and the order of reference of the House of Commons adopted on February 13, 2026, the special joint committee is meeting to study the eligibility for medical assistance in dying for those whose sole condition is mental illness.

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.

I'd like to confirm that sound tests have been done successfully. Before we continue, I would ask all persons participating to consult the guidelines written on the cards on the table. These measures are in place to help prevent audio feedback incidents and to protect the health and safety of all participants, including the interpreters. You will also notice a QR code on the card that links to a short awareness video.

I'd 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 mic, and please mute yourself when you're 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.

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. The clerk and I will manage the speaking order as best we can. We appreciate your patience and understanding in this regard.

Tonight I would like to welcome a whole bunch of new Liberals: Greg, Wade, Élisabeth and Peter. Welcome to the committee.

Some members are here permanently, and some are not here permanently. It gets too complicated, so I'm just going to forgo explaining all that.

For the first hour, we have two people testifying.

In the room is Professor Brian Mishara, director of the Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices, Université du Québec à Montréal. Online, from the Centre for Addiction and Mental Health, is Sanjeev Sockalingam, senior vice-president of education and chief medical officer.

You will each have the floor for approximately five minutes, and then there will be a series of questions. Since there are only two witnesses, you can go a little bit over. I will raise a piece of paper when you have about 30 seconds left, so you know your time is coming to an end.

With that, we'll start with Professor Mishara.

Professor Mishara, you have the floor.

**Professor Brian Mishara (Director, Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices, Université du Québec à Montréal, As an Individual):** Honourable senators and members of the committee, I've spent my life working in suicide prevention. I was president of the Canadian Association for Suicide Prevention and the international association. I am founder of the Quebec association for suicide prevention. I also work with the World Health Organization in training, research and policies.

I believe MAID should be available when suffering is not remediable by other means. However, in the case of mental illness, this is not possible to determine. I believe suicides are preventable, even in seemingly hopeless situations. I agree with the position of the International Association for Suicide Prevention that the overlap between MAID requests and suicide makes it impossible to distinguish between them and that MAID for mental illness will undermine suicide prevention by communicating that death is a viable alternative to treatment.

I don't think I have to say much about irremediability. Other people have talked about its impossibility to be determined with mental illness. No one can accurately predict whether a patient who failed to respond to multiple past treatments will respond to the next treatment or not. Mental health diagnoses change. They are, unfortunately, unreliable. With common diagnoses like schizophrenia, if you ask two psychiatrists to independently make a diagnosis, in about one out of seven patients they will make different diagnoses. That means many people will get the wrong treatment unless or until their diagnosis is corrected. Over the course of 34 years, 86% of mental health patients have at least two diagnoses. According to research, virtually no one gets and keeps one pure diagnosis type.

We have an obligation to provide access to mental health treatment before providing access to MAID. In 2025, the Canadian Institute for Health Information found that 41% of adults with a mental illness said that their needs were met not at all or only partially, while 52% of young adults reported being able to obtain not any or only limited help for their mental illness. One out of three Canadians said they did not have access to mental health services because they were unable to pay the cost.

Some believe that requests for MAID are more reasonable or rational and that this can be distinguished from suicide. However, there is no discernible difference between the reasoning in MAID requests for mental illness and justifications given for suicide. Both people feel that their suffering is interminable and intolerable. Moreover, most important human decisions are emotional and not rational or reasoned. What are the most important decisions we make? They are who we marry, our career choice and even what type of car we buy. We cannot expect that while we are suffering from a mental illness, which can cloud one's thinking, things should be any different from other important decisions we make.

I held the Bora Laskin Canadian national fellowship in human rights research to study euthanasia in the Netherlands, where MAID for mental illness was legalized in 2002. Each year, only one or two requests were approved. However, recently, after news stories about people with depression who received euthanasia, requests skyrocketed in 2023, with 138 deaths. In 2024, it went up 60% more, with over 7,000 requests and 219 deaths. Most of the people who died and who requested it were depressed women living alone under the age of 24.

● (1835)

Alarmed psychiatrists petitioned the government to stop this practice. They said, “Introducing euthanasia as a sanctioned outcome reframes suicidality from a symptom requiring containment into a potential treatment endpoint, an acceptable 'treatment plan.'” I don’t want this to happen in Canada.

**The Joint Chair (Marcus Powlowski):** Thank you, Professor.

Dr. Sockalingam, you have five minutes.

● (1840)

**Dr. Sanjeev Sockalingam (Senior Vice-President, Education, and Chief Medical Officer, Centre for Addiction and Mental Health):** Thank you, Chair and members of the committee, for the invitation to appear today.

My name is Dr. Sanjeev Sockalingam. I'm the chief medical officer, the senior vice-president of education and a senior scientist at the Centre for Addiction and Mental Health, CAMH.

CAMH is Canada's largest mental health teaching hospital and one of the world's leading research centres in this field. I also oversee our medical assistance in dying service here at CAMH.

Over the past number of years, CAMH has made several submissions to government committees related to mental illness and medical assistance in dying. Our position has been, and remains, that we are concerned about the expansion of MAID to people whose sole underlying medical condition is mental illness.

We want to be clear that this position is not based on the belief that suffering caused by mental illness is not comparable to suffering caused by physical illness. The grievousness of an illness is subjective, and there is no doubt that, for some people, mental illness can be grievous and can cause physical and psychological suffering.

The irremediability of an illness, however, is an objective determination that must be based on the best medical evidence available. There are currently no established criteria or consensus among psychiatrists about whether or when a mental illness should be considered irremediable. That is because there is no evidence in the mental health field, at this time, to predict the trajectory of any one person's mental illness and to ascertain whether an individual has an irremediable mental illness. This has been discussed previously. Therefore, any determination that a person has an irremediable mental illness for the purposes of MAID would be inherently subjective and arbitrary.

In an attempt to address this problem, the Canadian Psychiatric Association, CPA, recently published initial guidance designed to help MAID assessors identify whether a person has an irremediable mental illness. I know this has also been discussed by this committee. We appreciate the CPA's efforts to create clarity around the process of assessment; however, it does not address our call for the creation of guidelines summarizing the evidence gap. Specifically, the guidance document does not offer MAID assessors evidence-based criteria that could be used to determine the trajectory of a person's mental illness. The CPA guidance only provides recommendations on a process to follow for assessing a person's mental illness. This leaves the guidance open to individual interpretation and could put people with mental illness at risk of accessing MAID when they do not actually meet the eligibility criteria.

The lack of evidence for how to objectively determine the irremediability of an individual's mental illness is the primary reason we remain concerned about the potential for MAID to be extended to people whose sole underlying condition is mental illness.

This concern is compounded by disagreement among physicians on whether or how a request for MAID can be differentiated from suicide intent, which is an extremely difficult task for psychiatrists. In fact, a new review of the research literature found no evidence to suggest that it is possible to reliably distinguish between the factors underlying a request for MAID and those underlying suicide intent.

While the CPA's first edition of MAID clinical guidance has a section on managing suicide risk across all phases of the MAID pathway, it does not provide concrete methods for helping clinicians determine if the request for MAID is due to acute distress, a symptom of a mental disorder—

**The Joint Chair (Marcus Powlowski):** I'm sorry, Dr. Sockalingam, but I believe there's an issue with translation.

[*Translation*]

**Hon. Greg Fergus (Hull—Aylmer, Lib.):** Yes, Mr. Chair. I would like the witness to slow down a bit, because the interpreters are having trouble keeping up.

[*English*]

**The Joint Chair (Marcus Powlowski):** Could you slow down a little, please, Dr. Sockalingam?

**Dr. Sanjeev Sockalingam:** I'm sorry. I'll slow down a bit.

**The Joint Chair (Marcus Powlowski):** Thank you. We'll give you a few extra seconds at the end.

**Dr. Sanjeev Sockalingam:** Thank you. Would you like me to repeat the last paragraph? Would that be helpful? Okay.

As I was saying, a new review on the research literature found no evidence to suggest it is possible to reliably distinguish between the factors underlying a request for MAID and those underlying suicide intent. While the CPA's first edition of MAID clinical guidance includes a section on managing suicide risk across all phases of the MAID pathway, it does not provide concrete methods for helping clinicians determine if the request for MAID is due to acute distress, a symptom of a mental disorder or an enduring desire to die.

Finally, but of utmost importance to extending MAID to people whose only medical condition is mental illness, there is the state of mental health care in Canada. We've heard that mental health has been and continues to be significantly underfunded compared to physical health care in our country, making it difficult for people to get the right care when and where they need it.

Demand for care continues to grow, while service capacity does not. One in three Canadians reports that their needs for mental health care are unmet or only partially met. In Ontario alone, over the last four years, mental health service volumes have increased by 66%. Access to mental health treatment also remains inequitable. That is why investing in mental health care and support should be the priority before any consideration is given to moving ahead with implementing a track to choose MAID.

In sum, only when we have evidence-informed, consensus-based criteria for determining the irremediability of a person's mental illness and for distinguishing between a request for MAID and suicide intent—and only when such criteria can be introduced into a well-resourced mental health system—would it be possible to offer safe, adequate and equitable MAID services to people whose sole underlying condition is mental illness. That is why CAMH recommends that the federal government delay indefinitely the extension of MAID eligibility to people whose sole underlying condition is a mental illness.

CAMH is happy to offer expertise to government, including sharing our recent evidence synthesis on irremediability, suicide and MAID and the gaps in the evidence base, when it's available.

Thank you.

● (1845)

**The Joint Chair (Marcus Powlowski):** Let me say that if you want to submit that, I think we'd be happy to receive it.

Now we go to our first round of questioning, with Mr. Lawton for the Conservative Party for five minutes.

**Andrew Lawton (Elgin—St. Thomas—London South, CPC):** Thank you very much, Mr. Chair.

Thank you, witnesses, for your very fascinating and well-informed testimony.

I'll be devoting my time to asking you questions, Dr. Sockalingam. I want to put a fine point on how you ended there. Your position, or CAMH's position, rather, is that we should delay indefinitely the expansion of MAID for mental illness as the sole underlying criterion. Is that correct?

**Dr. Sanjeev Sockalingam:** That is correct.

**Andrew Lawton:** We have heard testimony—overwhelmingly from psychiatrists, in particular—that has alluded to the very things you've alluded to here: that there is no reliable way to distinguish between suicidality as a symptom of mental illness and a good-faith request for MAID. We've heard about the impossibility of coming up with a standardized framework that would assess irremediability for mental illness.

Would you say from your experience that we have as close to a consensus as possible from mental health care practitioners on these points?

**Dr. Sanjeev Sockalingam:** I would say so. Again, we've done our own assessments within our institution, and this is what has come forward as a majority in terms of some of the concerns.

Again, I would say it's due to the lack of evidence that we have to really delineate between suicide intent and a request for MAID. Also, as you articulated, our ability to prognosticate irremediability is significantly limited, given changing diagnoses, diversity and access to treatment based on geographic region or socio-demographic factors, but also in terms of predicting response.

**Andrew Lawton:** Obviously, on a very charged subject, it can be very difficult to find consensus, but we do actually have a fair amount of consensus to delay the expansion.

My question for you is in terms of looking at what CAMH said ahead of 2024, which was that 2024 was too soon, and the government delayed it and delayed it again, and here we are with an extension yet again to 2027. You're saying that we should delay indefinitely. Is it your view that these issues can never be resolved? Or should we really be looking at a permanent cessation of this, ending this practice of kicking the can down the road, and just saying that, by design, this could never work?

**Dr. Sanjeev Sockalingam:** You're asking me to prognosticate on the research and science of mental health conditions. I don't think I can definitively say what the timelines are for us to really tackle and articulate some of these key things, particularly irremediability, for example.

For irremediability, I would say that we do not have sufficient evidence to prognosticate. There are still debates on differentiation of diagnoses among psychiatrists, and assessment.... Until we have solid research to identify people's trajectories and biomarkers and to improve our diagnostic and clinical assessment tools, the notion of providing safeguards for MAID for mental illness.... It will be severely limited. We're saying “indefinitely” because the timelines for the evidence to mature—to have that stability and safety.... It will take a significant amount of time.

I don't think kicking the can down...another three years, as you said, will substantially make a difference, because we need to invest significantly in research.

● (1850)

**Andrew Lawton:** Thank you.

Some of the testimony we've heard is from people who are not on the front lines of seeing patients with severe mental illnesses, as you are. Some witnesses have approached their testimony more from the realm of legal theory, saying that we can't discriminate between physical illness and mental illness.

In its 2023 submission, CAMH said, “health care...for mental illness is not comparable to...care...for physical illnesses.” I don't take, from this, that the two are unequal on a moral level. Rather, in a practical sense, there are significant differences there.

In the 30 seconds I have left, could you please elaborate on that, in this context?

**Dr. Sanjeev Sockalingam:** I'll be very brief on that.

For some physical health conditions, there are diagnostic markers and lab tests we can do to confirm a diagnosis and prognosticate someone's response to treatments.

We are not there with mental health and mental illness. A particular mental illness is defined more by differences in equities, in terms of access to treatments. These are probably more pervasive, given the nature of the illness and the social or demographic factors that are impacted.

**The Joint Chair (Marcus Powlowski):** Thank you, Mr. Lawton.

Now, for five minutes, we have Ms. Tesser Derksen.

**Kristina Tesser Derksen (Milton East—Halton Hills South, Lib.):** Thank you very much, Mr. Chair.

Thanks so much to the guests who are here today.

I want to follow up on what Dr. Sockalingam was talking about with respect to the CPA's guidance document, which I reviewed.

In particular, I want to talk about section 2, “Guidance for Assessing and Managing Suicide Risk of the Requester”. I've written down a portion of the document here.

It notes:

> Jurisdictions that allow assisted dying for persons with mental [health] disorders as the sole underlying medical condition have found that most Requesters have a history of suicidal ideation and (or) suicide attempts; however, the presence of a history of suicidality does not prevent the Requester from being eligible.

In your opinion, Doctor.... You touched on this a bit. My question is, do clinicians and providers have the tools available to make these assessments and to determine them with some degree of accuracy, particularly given a historical context of previous suicide attempts?

**Dr. Sanjeev Sockalingam:** That's a great question.

In the context of previous suicide attempts, much of our assessment is retrospective, as it relates to mental health conditions and prognosticating from that standpoint. From the standpoint of past suicide attempts or suicidality, I think it is difficult to untangle what a current request for MAID is from an active suicidal ideation or intent, because that's so intricately embedded in some of the major mental illnesses, like depression. There are high rates of suicidality in patients with schizophrenia or psychotic illness as well.

I would say that this is difficult for us to untangle on the front lines—whether someone's request for MAID is, in fact, no longer part of a past suicide intent or part of their current suicidality. It's really difficult on the front lines, and this is validated by experience in our clinical settings.

**Kristina Tesser Derksen:** Thanks for that.

You mentioned how, with respect to understanding irremediability or untangling suicidality from a more reasonably based request, the research is still out.

Is there research under way? Is there a plan? Are researchers looking at these biomarkers and different things? How developed is the research right now? Is this something we're not going to see for decades?

**Dr. Sanjeev Sockalingam:** That relates to the previous question as well. I think we have some signals of where we might be able to do research. We continue to request more funding and resources to do that research and to advance it, but it is still in the preliminary phase. That is why, for it to be widespread in clinical practice, we are recommending suspending this indefinitely. It's because of the time needed for that research to evolve.

**Kristina Tesser Derksen:** You mentioned funding. Oftentimes, some of these discussions come down to that. It's been a particularly important scope of this committee to determine whether or not provinces and territories are ready to offer these services and provide the assessments where they have capacity to do the assessments. On that basis, aside from funding, have you seen a willingness, in your opinion, in the provinces and territories, including Ontario, where you have experience, to address this, or does it appear that they are still far away from implementing the systems and guidance needed for clinicians and providers to make adequate decisions?

● (1855)

**Dr. Sanjeev Sockalingam:** Do you mean adequate decisions about MAID for mental illness?

**Kristina Tesser Derksen:** Yes.

**Dr. Sanjeev Sockalingam:** Yes. I actually sat on our provincial committee to tackle this question with our government, our centre of excellence for mental health and addictions and a local network as well—a committee of our major hospitals—to tackle this very question. I co-chaired that local committee. In fact, we advocated for consideration when there was a high likelihood, or a push, to consider MAID for mental illness implementation a couple of years ago. We were worried. We really wanted safeguards in place, and resourcing, because of the concerns I'm expressing today. There was not a willingness to put resources forward.

In fact, one of our other concerns is that this pathway, if it were to come to fruition, would be a way for people to bypass the long wait-lists for mental health treatment to get assessment. They would actually get assessment faster, in some cases, than those waiting years for mental health assessment and treatment. We really need to think about the pressures in our health care system. How are we prioritizing something like this versus providing and rolling out treatments that are effective for treatment-resistant depression, for example, which really links to irremediability? These are the kinds of ethical but financial considerations we have to make in the system.

**The Joint Chair (Marcus Powlowski):** Thank you.

[*Translation*]

Mrs. DeBellefeuille, you have the floor for five minutes.

**Claude DeBellefeuille (Beauharnois—Salaberry—Soulanges—Huntingdon, BQ):** Thank you very much, Mr. Chair.

My questions are for you, Mr. Mishara. I imagine you will understand what I am trying to convey.

If I have a chronic, incurable and persistent illness, I can choose to die with dignity by requesting medical assistance in dying. If I receive a diagnosis of dementia or Alzheimer's disease and I'm a Quebecker, I can write advance requests to remain and die with dignity, rather than living in a CHSLD, where I might no longer recognize my husband and children, would be incontinent, and would have a very poor quality of life, even in a highly supervised environment like a CHSLD. I have the right to make a choice; the act allows me to do that.

However, if I'm schizophrenic, if I have access to a psychiatrist, if I'm properly medicated, if I receive intensive mental health follow-up from my CLSC, if my loved ones are by my side and if, despite all of that, I have been suffering for many years, I come to the conclusion that I don't have the same rights as other citizens who are experiencing suffering. This is because psychiatrists and physicians can't agree on a clear framework for determining whether my recovery is still likely and whether there are still further treatment attempts that could reduce my suffering.

What bothers me, Mr. Mishara, is that we're creating categories of citizens who don't have the same rights. I understand that it is more difficult to determine, based on a person's history, whether someone can obtain medical assistance in dying when their only underlying medical condition is a mental health disorder. However, there are people, as we speak, who would meet all the criteria but don't have the same right as others. That troubles me.

What can you tell me that might convince me that these people are not being discriminated against?

**Brian Mishara:** It's not true that there is no research being done at present. There's a great deal of research, but all the research to date indicates that no one is able to say with certainty that, in six months or a year, or with another treatment, this person won't be glad to be alive. In addition, given the very limited access to mental health treatment, we have an obligation to do everything possible in terms of suicide prevention. Anyone who attempts suicide thinks in exactly the way you describe. The person believes that they can no longer endure their suffering, that death is the only way to put an end to end it and that nothing can be done. However, we are almost always able to prevent suicide.

● (1900)

**Claude DeBellefeuille:** I'm not talking to you about cases of suicide; I'm talking to you about a person with schizophrenia, for example, who has been receiving ongoing care for 25 years, who is medicated and who is well supported by those around her. As a legislator, I feel uncomfortable not taking her wishes into account and not listening to her when she says that she has had enough and that she suffers every day, despite all the assistance she receives. I wonder what to say to these people.

**Brian Mishara:** This person needs to be told that we're going to do everything we can to help. That person needs to have access to the right diagnostic services and the right treatments—

**Claude DeBellefeuille:** I'm sorry to interrupt you, but I only have five minutes.

You take certain things for granted. I myself have had people come into my office who had been receiving ongoing care and intensive mental health follow-up for 20 or 25 years, but who were still suffering. Why aren't these people allowed to be considered as full people who can make their own choices, choices that concern them?

When a person has been treated by a psychiatrist for 25 years, is taking medication, receives intense home-based follow-up, has loved ones around them, and is still suffering, what hope can I offer that person for the future?

**Brian Mishara:** That person could speak to a number of people who testified before a parliamentary committee in Quebec before Quebec decided not to allow medical assistance in dying for people suffering solely from a mental illness. The committee heard from individuals who were in exactly the situation you're describing. They told the committee that, if medical assistance in dying had been available to people with mental health issues, they would be dead, because they met all the requirements three years earlier. They said that they were now very happy to be alive and that they had received good treatment.

If it were possible to predict who will be happy to be alive in a year or two and who will continue to suffer, that would be different. However, so far, all the research indicates that this isn't the case. Even research on schizophrenia indicates that symptoms lessen with age.

**The Joint Chair (Marcus Powlowski):** Thank you very much.

Senator Dalphond, you have the floor for three minutes.

**Hon. Pierre Dalphond:** Good evening.

Thank you to the witnesses for being here.

Professor Mishara, you concluded your opening remarks by mentioning some data on the Netherlands. You talked about an exponential increase after one, two, three or four cases a year. Now, the numbers may be much higher. Could you give us more details and provide the committee with the source of your information?

**Brian Mishara:** I will send you the sources.

The Netherlands has a long assessment process. It sometimes takes up to two years. They accept 3% of applications, and even that is controversial.

That said, there's a suicide-related phenomenon that has been well documented for a long time, known as the Werther effect. It's named after Goethe's book *The Sorrows of Young Werther*. When that book was published over 200 years ago, there was an epidemic of suicides across Europe, in every country where the book was published. These were young people who—

● (1905)

**Hon. Pierre Dalphond:** Excuse me, Professor Mishara, but time is running out. I'd like you to come back to the data you mentioned.

**Brian Mishara:** Okay.

**Hon. Pierre Dalphond:** I understand the phenomenon, I just want you to tell us specifically about the experience in the Netherlands.

**Brian Mishara:** Okay.

As a result of this phenomenon, when a method of suicide is publicized in a given country, the number of suicides increases among people with mental illness, who are particularly vulnerable and who use that method. It isn't just a substitution effect; these are people who wouldn't have died if there hadn't been that publicity.

What happened was that there were photos and descriptions of the case of a young woman who had received medical assistance in dying for depression, and, since there had been publicity of suicides on the Montreal metro, the Jacques-Cartier Bridge or the Vienna metro—

**Hon. Pierre Dalphond:** Again, can you give us the numbers and the ages of the people? The numbers are going up and the age is going down—

**Brian Mishara:** All of a sudden, instead of a—

**Hon. Pierre Dalphond:** You have 15 to 20 seconds left.

**Brian Mishara:** Okay. According to the figures I gave, in one year, the number of deaths went from 2 to 138. The year after that, there were 219.

**Hon. Pierre Dalphond:** Did you say that some people were young?

**Brian Mishara:** The majority of the people who made those requests were women who lived alone and had been diagnosed with clinical depression.

The message being sent to suicidal people is that this is a way to treat their depression.

**The Joint Chair (Marcus Powlowski):** Thank you.

We would appreciate it if you could send us that study.

[*English*]

Next is Senator Moodie for three minutes.

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

Dr. Mishara, I have to come back to this, because I'm puzzled by what I'm hearing. I want to put a scenario to you.

This committee has heard testimony that, here in Canada, we should not allow persons with mental illness as their sole condition to access MAID. This applies even when they are suffering intolerably, even if they meet the criteria required and even if they wish to end their lives and would and will do so if they do not get access to MAID.

Do you share this view, Dr. Mishara?

**Brian Mishara:** I do not at all share that view.

I have spent my life working in suicide prevention. I have started help lines in different countries and in Montreal. I've worked—

**Hon. Rosemary Moodie:** I have another question for you, Dr. Mishara.

**Brian Mishara:** I was—

**Hon. Rosemary Moodie:** You will get a chance to answer.

Is it your view, Dr. Mishara, that people who are suffering intolerably and who have tried all appropriate levels of treatment and all appropriate supports, all of which these individuals, who continue to suffer, deem to have failed, should keep trying these failed treatments and that they must wait for the realization of some research to perhaps come in the future? Is it your opinion that they must continue to live with this intolerable suffering? Is this your view, Dr. Mishara?

**Brian Mishara:** I believe that, first of all, the treatment for suicide involves a human being caring about them, believing that they can find hope regardless of this hopeless situation they feel they are in, and embarking with them on helping them to get the help and support they need.

If you look at the reasons people give, it is not because of the symptoms of their illness. It is often because of loneliness, an inability to be in a relationship or have a job and feeling the stigma of a mental illness and its impact along those lines. If you look at the reports of why people are asking for MAID, even not for mental illness, it's almost never physical pain. It's emotional suffering. It's equally a result of living in our society where, when you have a mental illness, you can't get a good job and people abandon you.

● (1910)

**Hon. Rosemary Moodie:** Thank you for that.

I have one more question—

**The Joint Chair (Marcus Powlowski):** Thank you, Senator. Your three minutes are up.

Go ahead, Senator Osler, for three minutes.

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

Thank you to both witnesses for being here today. I'm going to start with Dr. Sockalingam and go to Professor Mishara if there's time.

This committee has heard testimony from different experts on what they think patients should do, and less from patients with lived experience, particularly those who are in support of MAID where mental illness is the sole underlying medical condition.

It's a two-part question.

My first question, Dr. Sockalingam, is this: Are you aware that there are people with lived experience with mental disorders who have publicly stated a willingness to bring a different perspective from those who have been invited to appear before this committee?

My second question, would you agree that having people with lived experience, with a diversity of views, experiences and expertise, before the committee would allow the committee to better meet its obligations to make recommendations on this difficult issue?

**Dr. Sanjeev Sockalingam:** Again, I would say that in my experience in the process of our own journey at CAMH, in our recommendations and statements, previously and currently, we've tried to engage the most diverse patients, including people who have stated, with lived experience, that they're in support of MAID for mental illness.

We are still left with the challenge of.... We're not arguing "grievousness" from that standpoint, but there is the definition of "irremediability" and the differentiation of whether that request is occurring and whether people are seeking MAID in the context of their mental illness. Is that differentiated or can that be differentiated from suicidal intent as part of the illness itself?

I think, from that standpoint, your question is should we include people...? We should always, and we have tried to at CAMH as well. I would agree.

We're still stuck with some of the.... I'm an assessor for MAID. I'm still stuck with the struggle, based on the lack of evidence, guidance or objectiveness, to feel comfortable that I'd be making a decision and be able to prognosticate for an individual what their long-term course would be. That's the tension here.

The answer is, yes, we should have diverse views.

**Hon. Flordeliz (Gigi) Osler :** Thank you.

What I've heard from you is you said, yes, you're aware of people with lived experience and diverse opinions, and at CAMH you did try to hear from a diversity of patients with views.

**Dr. Sanjeev Sockalingam:** One hundred per cent.

**Hon. Flordeliz (Gigi) Osler :** Professor Mishara, I'll ask the same question of you.

**The Joint Chair (Marcus Powlowski):** Professor, you only have about five seconds, so answer briefly.

**Brian Mishara:** I appreciate how much people care about the suffering, but suicide prevention works. Every single person I have spoken with who was suicidal felt exactly like described, and most of them got hope.

**Hon. Flordeliz (Gigi) Osler :** I understand, and I don't want to cut you off. I know we're out of time.

My question was about centring patients—

**The Joint Chair (Marcus Powlowski):** Thank you, Senator Osler. Your time is up.

Go ahead, Senator Wells, for three minutes.

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

Professor Mishara, in your previous testimony to this committee in 2022, you stated that, "In the Netherlands only 5% of requests for MAID for a mental disorder are granted" and "Even in medical cases of terminal illness, 40% of requests are refused because the doctor believes there [are ways to treat] suffering, and hardly any of those who are refused repeat their request after trying the treatments."

Do you know whether these statistics are still the case in the Netherlands—I think you went into that a little bit—and if so, wouldn't that demonstrate that the Netherlands actually has a robust safeguard system for MAID MI-SUMC that Canada can learn from?

**Brian Mishara:** That's gone down a little bit. It's 3% of the requests for MAID for mental illness that are approved now. There is one clinic that gets 85% of the requests, and they approve 13.6% of their requests.

The problem is that this was sort of under the radar. There were a couple of cases—

● (1915)

**Hon. Kristopher Wells:** I don't want to go too much into that. It's maybe not relevant to our example here in Canada.

The question was whether there is anything you think we can learn from the Netherlands' experience—you said MAID requests are actually going down—for the Canadian experience.

**Brian Mishara:** The numbers for mental illness are skyrocketing now. The percentage they're approving has gone down about 40%. It's gotten to the point where it's an epidemic of young people, mostly.

**Hon. Kristopher Wells:** I have limited time.

You don't think there's anything Canada should take or learn from the experience in the Netherlands. Is that correct?

**Brian Mishara:** There's a danger in offering MAID for mental illness, because this communicates to a vulnerable population, in which, in many instances, suicidality is a symptom of their illness.... The desire to die is symptomatic of the illness, and MAID has caused a phenomenon where it's being considered an alternative to treatment rather than getting treatment.

**Hon. Kristopher Wells:** Are you saying that talking about MAID can lead to a contagion of people wanting to pursue MAID?

**Brian Mishara:** Showing any death by suicide or by MAID for someone with a mental illness to vulnerable people who have a mental illness and have considered suicide will increase the number of people who will die by that method and the number of people who wouldn't have died but then choose MAID. This happens if you talk about a suicide on a bridge or the metro or someone with a mental illness—

**Hon. Kristopher Wells:** Is there actual research that focuses on MAID?

**The Joint Chair (Marcus Powlowski):** Senator, your three minutes is long—

**Hon. Kristopher Wells:** Could you send that to us?

**The Joint Chair (Marcus Powlowski):** Yes, if you could send us all of these studies from Holland, as we've previously mentioned, we'd appreciate that.

**Brian Mishara:** I shall do so.

**The Joint Chair (Marcus Powlowski):** We will now go to the second round of questioning.

Mr. Cooper, you have three minutes.

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

Dr. Sockalingam, consistent with the testimony of other psychiatrists who came before this committee, you indicated that there is no specific scientific way to project the future course of mental illness. Given that, would it be fair to say that any prediction would amount to a clinical hunch?

**Dr. Sanjeev Sockalingam:** Clinical judgment is where we are basing any kind of prediction at this current time. As I said before, research has been under way for several years to try to explore indicators to help us prognosticate better, but we are a long way away.

**Michael Cooper:** Would it be fair to say that it's quite common for psychiatrists to disagree with each other on the future course of mental illnesses?

**Dr. Sanjeev Sockalingam:** I would say so, and even on the diagnosis itself. As others have highlighted, there are studies showing—including from the initial field studies of the DSM-5, for example—that there are differences in diagnosis and that they change over time.

**Michael Cooper:** Given the difficulty in predicting irremediability and the fact that there is no scientifically objective way, would it be fair to say that if this expansion were to move ahead, there would be a high rate of error in which persons who could get better and go on to lead healthy and happy lives would have their lives prematurely ended?

As Dr. Sonu Gaind said, it would be akin to flipping a coin. Would you agree?

**Dr. Sanjeev Sockalingam:** Yes. We would be using clinical judgment. If we were to go forward, there would be times when there might have been a chance to provide treatments that people may not have had access to or not been aware of, and there may be times when a person's illness would have improved but we may have predicted incorrectly.

● (1920)

**Michael Cooper:** You spoke about the CPA guidance, and you noted that it fails to provide any scientific criteria with respect to predicting irremediability, likely because there are no such criteria.

The CPA guidance does use the practice standard from Health Canada, but that looks back on a retrospective basis. I take it you would agree that's insufficient. Is that correct?

**Dr. Sanjeev Sockalingam:** That is insufficient.

I applaud the CPA for trying to come up with guidance, but we're limited by the literature and the evidence, and the evidence is based on retrospective data. It's a process document as opposed to criteria or an objective assessment.

**The Joint Chair (Marcus Powlowski):** Thank you.

Mr. Maloney, go ahead for three minutes.

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

Thank you to both of our witnesses.

Dr. Sockalingam, I will continue with you.

You said at one point that any such diagnosis is entirely subjective when it comes to mental illness. Do you say that to some degree because the symptoms are subjective?

**Dr. Sanjeev Sockalingam:** The symptoms are not subjective, and I wouldn't say it's entirely subjective. We have diagnostic criteria that are based on symptoms and have evolved over time.

We don't have objective markers. We don't have a test, and those markers aren't necessarily limited to diagnosis. They're limited to even prognosis. For example, in certain neurological conditions and cancers, we can prognosticate more definitely on who's going to respond to what treatment and for how long and what their duration of illness might be.

**James Maloney:** I think we're saying the same thing.

**Dr. Sanjeev Sockalingam:** Yes.

**James Maloney:** You just put it much better than I could have.

When people come to you or another psychiatrist with a mental health condition, you're relying on information that they are conveying to you verbally. There are some indicators and markers you can use, but unlike a physical medical condition where there's an MRI, an X-ray or something, there's not as much physical evidence available to you as a diagnostic tool.

Is that right?

**Dr. Sanjeev Sockalingam:** That is correct. We have some data points, but nothing that we could definitively hang our hat on for this particular discussion today.

**James Maloney:** That's what's going to lead to the inconsistent diagnosis that Mr. Cooper was alluding to. If somebody has terminal lung cancer, and 10 doctors examine that patient, they're all going to agree the patient has lung cancer. If 10 psychiatrists examine somebody who has a mental health condition, you're going to get different diagnoses.

**Dr. Sanjeev Sockalingam:** That is correct. It happens in our clinical care when people are admitted to different hospitals.

**James Maloney:** Very rarely are you going to get 10 out of 10. It could happen, but it's very rare and it's not going to happen in the vast majority of cases.

Is that fair?

**Dr. Sanjeev Sockalingam:** That is correct.

**James Maloney:** Okay.

I want to talk about another thing. We've been talking about consensus at this committee quite a bit, and I think at times people are confusing ethical consensus with medical consensus.

In the situation I'm talking about with lung cancer, you will get a consensus. If there's a lack of consensus in the medical community or in the general public about whether to proceed with MAID, it's basically an ethical issue and a moral issue, whereas when you're talking about mental health, really the consensus you can't achieve is the medical consensus.

Is that fair?

**Dr. Sanjeev Sockalingam:** That was what I was referring to in my statement. That's correct.

It's the consensus on irremediability and the consensus on differentiating suicidal intent from a request for MAID or a persistent desire to die.

**James Maloney:** That takes me to my third point.

**The Joint Chair (Marcus Powlowski):** Make it brief.

**James Maloney:** Okay.

We're talking about equal rights to MAID for people with mental health versus physical conditions. Everybody agrees they should have equal rights, but lacking the ability to have this definitive diagnosis makes it hard to provide that those rights are safe.

Is that fair?

**Dr. Sanjeev Sockalingam:** Exactly. It's safe...and I would just underscore the accessibility—

**James Maloney:** "Protected" is a better word.

**Dr. Sanjeev Sockalingam:** Yes, and the accessibility of treatments that are effective is also a concern.

**The Joint Chair (Marcus Powlowski):** Thank you, Mr. Maloney.

[*Translation*]

Mrs. DeBellefeuille, you have the floor for two minutes.

**Claude DeBellefeuille:** Thank you, Mr. Chair.

Professor Mishara, we agree that not everyone whose only medical condition is a mental illness has suicidal thoughts or wants to commit suicide. For some time now, I have felt that a close connection gets drawn between a mental health issue and a desire to end one's life. In my practice, I have met people whose only health issue was a mental illness and who weren't thinking about suicide. They want their suffering to stop, they want good treatment and they want good care. It isn't necessarily a cause-and-effect relationship.

I sometimes get the impression that, to prevent medical assistance in dying from being offered to people whose sole underlying medical condition is a mental illness, mental illness is automatically linked to suicide. Am I wrong to think that not everyone with a mental health problem thinks about suicide?

Is it reasonable for a person who has tried a number of things, undergone treatments, listened to their psychiatrist and taken their medication to have the choice to die with dignity?

It isn't the same thing, Professor Mishara. We seem to be confusing a lot of things and drawing connections that seem a bit narrow to me.

● (1925)

**Brian Mishara:** Excuse me, but I'm going to put on my researcher's hat again. Research indicates that more than 90% of people in Canada who die by suicide have been or could have been diagnosed with mental illness.

**Claude DeBellefeuille:** That means there are 10% of people who don't have a mental illness and who have rights.

**The Joint Chair (Marcus Powlowski):** Thank you very much, Mrs. DeBellefeuille.

[*English*]

Senator Osler, you have two minutes, please.

**Hon. Flordeliz (Gigi) Osler :** Thank you, Mr. Chair.

My question is for Professor Mishara.

Would you agree that a parliamentary committee tasked with making recommendations on this important and complex issue should have before it not only the full range of expert evidence but also patients—

**Andrew Lawton:** I have a point of order.

Mr. Chair, I'm rooting this in chapter 20 of *House of Commons Procedure and Practice*. This committee has set out, through the work of the subcommittee, a very robust plan, including people with lived experience. The scope of this committee is not to review or ask witnesses to weigh in on how to structure parliamentary committees, which is what the senator is now devoting her second round of questioning to.

The line of questioning is out of scope, but it's also misrepresenting the facts of how this committee is undertaking its work.

**The Joint Chair (Marcus Powlowski):** I would suggest, and the chair has some discretion over this, that the line of questioning is broadly related to the topic under discussion. She has one minute and 35 seconds left. I don't think it's going too far out of line to let her ask a question.

**Hon. Flordeliz (Gigi) Osler :** Thank you, Mr. Chair.

To be brief, professor, and to allow you the optimal time to answer, can you tell us, from your experience as a researcher, about hearing from patients with a diversity of experiences?

**Brian Mishara:** It certainly enriches our understanding of how to proceed and better help people, because it gives a sense of their whole life and all the complications of their life that are associated with their suffering.

I agree that the suffering of someone with a mental illness can be just as acute or worse than that of someone with a physical illness, but it is not because of the symptoms. It's usually because of a whole constellation of aspects of living with a mental illness, like frustrations, getting help and so forth.

It's more complicated, because in many diagnoses, one of the symptoms of depression is hopelessness. It's a symptom of the illness, so no matter how good things seem, you're going to think it's hopeless: “I'm never going to feel better.” This is related to the illness, which is not being adequately or correctly treated at that point in time. It certainly can point to things a little out of the technical scientific discussions: As a society, how can we better help people with a mental illness so they won't feel so desperate?

It's not just in terms of mental health treatment, which is very difficult to get in Canada, but also in terms of all the other aspects of the life of someone with a mental illness that is profoundly influencing their ability to live a good life in Canada despite their illness.

● (1930)

**The Joint Chair (Marcus Powlowski):** Thank you, doctor.

**Tamara Jansen (Cloverdale—Langley City, CPC):** I have a point of order as well, just before we move on.

**The Joint Chair (Marcus Powlowski):** Go ahead on the point of order.

**Tamara Jansen:** I just want to make sure I correct the record.

Last night we had someone with lived experience, so we need to correct the record after what the senator just said.

Thank you.

**The Joint Chair (Marcus Powlowski):** Your point is noted.

Senator Wells, you have two minutes.

**Hon. Kristopher Wells:** Thank you.

My question is for Dr. Sockalingam.

Since the Canadian Psychological Association wasn't invited to this committee to discuss its guidance, I want to ask you this: What is CAMH doing to develop the objective markers to determine the mental health condition required?

**Dr. Sanjeev Sockalingam:** I'll take that in a few parts. First, one of the reviews cited came from CAMH, and the recent review is under publication on the difficulty of differentiating suicidality versus requests for MAID. That's part of the work we've been undertaking in the last couple of years. We have another review and synthesis of the literature on irremediability, which has informed our statement.

Second, we are an academic research hospital. We are conducting numerous studies, including looking at youth and following youth over time to look at trajectories for people in differentiation of illness, and also looking at more personalized care in terms of treatment response.

Last, just yesterday, we published a paper on treatment-resistant depression treatments and what can be effective for people who have not responded to other treatments before. We will continue to do that research and work to develop those treatment options for people who may not have responded to many of our traditional treatment forms.

**Hon. Kristopher Wells:** Dr. Sockalingam, you said, in a New York Times article published in 2023, that CAMH has “been clear that we have concerns about expansion at this time”, when talking about MAID for MI-SUMC.

Based on your testimony today, do you still feel that we're not ready for this extension? If so, do you think Canada will ever be ready?

**Dr. Sanjeev Sockalingam:** I'll just reiterate my statement. I do not think we are ready at this time, and I don't think so for the foreseeable future, to be honest, because we need to do further research, seek evidence and evolve our approach for assessment and treatment for mental health, both for individuals and for the system at large. Will I say that ever? I won't go that far. I'm saying we can't predict the course of mental illness. I'm not going to predict the future of psychiatric research.

**The Joint Chair (Marcus Powlowski):** Thank you, Dr. Sockalingam and Professor Mishara, for your valuable testimony. We appreciate your coming out tonight.

With that, we'll suspend and wait for the next group of witnesses to arrive.

● (1930)

_____________________(Pause)_____________________

● (1935)

**The Joint Chair (Marcus Powlowski):** I call the meeting back to order.

Let me introduce the witnesses for the second hour. In the room we have Mr. Neil Belanger, chief executive officer of Indigenous Disability Canada. By Zoom, we have Dr. Rod McCormick, professor.

Dr. McCormick, you're here as an individual. Is that right?

**Roderick McCormick (Professor, As an Individual):** That's right.

**The Joint Chair (Marcus Powlowski):** Thank you.

Maybe we'll start in the room with Mr. Belanger.

You have five minutes. When there are about 30 seconds left, I'll hold up the paper, and, as we discussed, you can go a little over the time.

**Neil Belanger (Chief Executive Officer, Indigenous Disability Canada):** Thank you, Mr. Chair.

Thank you—

**Hon. Rosemary Moodie:** I have a point of order.

Mr. Chair, is it possible for us to learn a bit more about our witness? We have in front of us a person who is a professor. Do we know anything more that you can share with us about this esteemed witness in front of us? That's not my job.

**The Joint Chair (Marcus Powlowski):** Mr. Belanger is the chief executive officer of Indigenous Disability Canada. Is that who you're talking about?

**Hon. Rosemary Moodie:** Yes.

**The Joint Chair (Marcus Powlowski):** That's all the bio I have on Mr. Belanger. If Mr. Belanger would like to add some remarks about his bio, that would be at the expense of other parts of his speech.

**Hon. Rosemary Moodie:** Can you request that, Mr. Chair?

**The Joint Chair (Marcus Powlowski):** No. It's his time. It's his five minutes, and he can do with it as he pleases.

It's your five minutes; it's not the senator's time to ask questions.

**Neil Belanger:** Thank you.

**The Joint Chair (Marcus Powlowski):** She can ask questions during her three minutes.

**Neil Belanger:** Thank you again, committee, for having me here.

My name is Neil Belanger. I'm a member of the Lax Seel Clan in the House of Nikateen of the Gitxsan Nation. I'm also the chief executive officer of Indigenous Disability Canada, IDC. IDC is a national indigenous cross-disability organization that has provided disability-related supports and services across Canada for the past 35 years.

Before I begin, I would like to recognize and thank the Algonquin Anishinabe people, whose territory we are meeting on today.

IDC was the lead organization working with over 55 national disability groups on Canada's second and third reviews of the CRPD. From this review, the United Nations Committee on the Rights of Persons with Disabilities recommended to Canada, under article 10, which is the right to life, to repeal track 2 MAID, including the provision to expand MAID to those whose "sole underlying medical condition is a mental illness". To date, despite one year passing, Canada has failed to respond.

On a daily basis, IDC works with individuals and families from across Canada with disabilities, including those with mental illness. Our work is to assist in obtaining necessary disability and health-related supports and services. This is so individuals and families can have a good life, where their disability and health-related needs are met.

IDC works with thousands of individuals annually, including those who have been approved for track 2 MAID, those who have applied for it and those who are considering requesting it.

Individuals we have worked with include those from the deaf community who were approved for track 2 MAID. They requested MAID due only to the denial of requested technology and disability accommodations while in the correctional system. This denial resulted in their inability to participate in group sessions and activities or to communicate with their legal representatives, causing increased mental stress and increased isolation, which in turn eroded their will to continue.

Other individuals IDC has worked with and is currently working with have conveyed that they are intending to apply for MAID due to inadequate housing, discrimination and racism experienced in health care, and the general lack or inadequacy of disability services and supports on most levels, all of which have greatly impacted their mental health and their desire to go on.

IDC has been in contact with persons approved for track 2 MAID who, despite being approved for state-assisted death, haven't been assisted in obtaining their disability tax credit, DTC. The DTC is a gateway benefit for other benefits, including the registered disability savings plan, Canada disability benefit, Canada workers benefit disability supplement and the Canadian dental care plan, etc. These are all benefits that could be significant in alleviating a person's suffering.

It seems unimaginable that state-assisted euthanasia could be facilitated and approved while, at the same time, the individual received no assistance in accessing their DTC before, during or after their MAID assessment.

Track 2 MAID, including MAID where the sole underlying medical condition is a mental illness, has been framed by pro-euthanasia and assisted suicide groups as a so-called "equality right". This equality right, however, is reserved solely for those who are considered to be unequal. No other group is afforded access to this state-provided euthanasia, regardless of their suffering. No, this equality right is only for those who are commonly portrayed as less than, defective and wanting—people no one would ever want to be.

Overwhelmingly, past and present committee members have heard from expert witnesses—persons with disabilities, indigenous leaders, clinicians and disability organizations—all of whom said that the reason many persons with disabilities and mental illness request or even consider track 2 MAID is the lack or inadequacy of available services and supports.

These gaps in services leave persons with disabilities and with mental illness in isolation, frustration and desperation. Life for many becomes too hard. Again, it's not because of their disability or mental illness but because of the systems they are forced to endure and the suffering that those systems inflict.

We could fix those systems and ensure that persons with disabilities and mental illness have the necessary supports to lead a good life, but in Canada, we are opting to present them with state-assisted euthanasia as an acceptable and normalized alternative.

Persons with disabilities and mental illness taking or contemplating MAID due to the lack or withholding of necessary and adequate supports and services is not a voluntary action by them, nor is it done freely, as some might suggest. It is, in fact, a response to tactical omissions within our disability, health and social systems. It is a result of external pressures, and it is the definition of coercion.

During the previous and current session of the AMAD committee, you've heard from expert clinicians who have overwhelmingly testified that mental illness can never be deemed to be irremediable and that there are no standard medical tests nor specific clinical criteria existing to determine irremediability.

● (1940)

Simply put, if this expansion is allowed, there is no way to predict that the individual euthanized could not have led a good life and a full life once proper supports and treatments were in place. There are no safeguards, policies or procedures that can be put in place to correct this.

**The Joint Chair (Marcus Powlowski):** Thank you.

We have Dr. McCormick for five minutes, please.

**Roderick McCormick:** *Shé:kon*.

My name is Rod McCormick. I'm a Mohawk and a professor and research chair in indigenous health at Thompson Rivers University. I would like to thank the committee for the invitation to provide input on this impending legislation that has literally life-or-death implications.

For context, I'm talking to you from my house on my partner's reserve of Tk̓emlúps te Secwépemc in Kamloops, B.C., where I'm the director of an indigenous research centre called All My Relations. Academically, I've been recognized as a distinguished university scholar and a fellow at the Royal Society of Canada. I'm also a mental health clinician who has had almost 40 years of experience as a mental health service provider and consultant for indigenous peoples. One of the consulting projects I'm working on that has pertinence to MAID is the development of a provincial indigenous suicide prevention and life promotion strategy for B.C. on behalf of the First Nations Health Authority.

The expansion of MAID for mental illness goes against every effort I have made in my work in suicide prevention and life promotion. In my work with clients suffering from mental illness and mental anguish, I have worked with numerous clients who are suicidal. Upon recovery, many of them shared with me what they learned from this challenge in life. They realized that suicide was a permanent solution to what proved to be a temporary problem. They realized that they were not thinking clearly at the time they were suicidal. They realized that they had isolated themselves from friends, family and those who could help them. They realized that they were looking for an easy way out. They admitted that they were not aware of the many treatment options that worked for others. They realized in retrospect how their suicide would have devastated their friends and families.

From a study I conducted with 25 indigenous people who recovered from being suicidal, it turns out that responsibility to others is a great protective factor. Although I obviously cannot speak for all indigenous people, the pattern I'm seeing in the expansion of MAID is an abdication of responsibility by the Government of Canada. Instead of making every effort to provide the range of mental health services needed by indigenous people to overcome their pain, Canada is instead imposing upon them the burden of deciding whether or not they should choose a government-sanctioned and medically sanctioned permanent solution to what could easily be a temporary problem.

Many Canadians may not realize that indigenous peoples are a vulnerable population. Due to our history of colonization and ongoing oppression, we have very high rates of unresolved trauma and unresolved grief. We watch our relatives experience death in the custody and care of social services and the justice system. We watch our people die of complex diseases and higher rates of disease than the general population. Our suicide rates are, on average, three times higher than the general population's. Many indigenous communities are affected by minimal economic and employment opportunities, remoteness, accessibility barriers, transportation issues and limited access to necessary disability, health and social services and their associated professionals. When indigenous people are one of the most vulnerable sectors of Canadian society, it seems immoral to provide an easy path to death versus the mental health assistance that other Canadians receive.

MAID is culturally biased, in my opinion, in that it emphasizes the individual's right to autonomy and choice without taking others into consideration. Other cultures do not place such a high value on individualism and autonomy. By encouraging indigenous people to put individual rights ahead of collective responsibilities, Canada is, in a sense, perpetuating colonization.

What do I mean by an abdication of responsibility? If we don't provide the care that people need, then we shouldn't be offering them death as an alternative to that care. There is a failure to understand that appropriate and timely help is the key to survival. Instead of making every effort to provide the range of mental health services needed by Canadians to overcome their pain, Canada is imposing upon them the burden of deciding as an individual to choose death instead.

Figuring out how to address mental illness for the vulnerable is difficult and costly, but resorting to the easy solution of lethal injections is, in my opinion, irresponsible and immoral. Responsibility is the ability to respond—literally to be “response-able”. It seems that the governments, provinces and communities do not feel like they're able to respond to the mental health needs of Canadians if they are now defaulting to doctor-assisted suicide.

● (1945)

How can we, as Canadian citizens, empower our communities and governments so that they feel able to respond? Until we figure that out, I urge the Canadian government to continue to prohibit the use of MAID for mental illness and to instead take the responsible path by improving the mental health services available to indigenous people and to all Canadians.

**The Joint Chair (Marcus Powlowski):** Thank you. You were almost right on five minutes.

We have Ms. Jansen for five minutes.

**Tamara Jansen:** Thank you, Dr. McCormick.

You're doing the hard work of building a suicide prevention and life promotion strategy in indigenous communities, where your focus is on connection, culture and keeping people alive. At the same time, the broader system is moving toward offering assisted death for those very same mental health struggles. In communities where decisions are deeply connected to family, culture and future generations, that seems like a very confusing message.

How do you explain that to the communities you serve? You're working to prevent suicide on the one hand, while on the other hand, the government is expanding access to state-sanctioned death for the mental health conditions your strategy is designed to address.

• (1950)

**Roderick McCormick:** Yes, you're right. There's that conflicting message. I don't have any answers. I don't have any easy answers for why one system is pushing for one thing and why another.... The culture is not.... It's just not the way we operate on an individual basis like that.

That's a good point. I don't really have an answer for it.

**Tamara Jansen:** Many indigenous leaders have spoken about how past systems imposed outside values and decisions onto their community, often without fully respecting those cultural frameworks around life, responsibility and care. When we look at MAID, it's built largely around individual autonomy and personal choice, but that's not how many indigenous communities understand decision-making. It's often relational and tied to family, community and future generations.

Do you see a risk that expanding MAID, especially for mental illness, could reflect a similar pattern of imposing an individualistic framework onto indigenous communities?

**Roderick McCormick:** Yes, definitely. You got that right.

That cultural conflict that focuses on individualism is one of the reasons why there are mental duress and struggles for people. It just adds to the pile of the media, the health system and the educational system, saying, “No, you have to be an individual. You have to master your own environment.”

It's a very biased and culturally encapsulated view of how you should function in life, and that goes against a lot of community, family and traditional values.

**Tamara Jansen:** I attended a Métis Nation B.C. presentation, where Dying With Dignity was presenting MAID as, essentially, another treatment option and framing it as compassionate and loving. However, in the same conversation, Sheryl Sullivan, who is a Métis nurse practitioner, pushed back and said clearly that MAID should not be the alternative to a lack of services, because when a system presents death as a solution in communities that are still fighting for basic access to care, it's not a choice, but more like something being introduced into a gap.

From your perspective, is there a risk that framing MAID in this way, especially where services are lacking, reflects the typical pattern where outside systems and values are being layered onto indigenous communities instead of addressing the underlying needs?

**Roderick McCormick:** Absolutely. When we're given those messages, it's more of the same, it seems.

I'm sorry. I wish I could give more optimistic answers to your questions, but I totally agree with what you said.

**Tamara Jansen:** In your estimation, how many indigenous Canadians suffer from a mental illness and could be at risk of MAID with this expansion?

**Roderick McCormick:** I don't have statistics in front of me, but generally, we have higher rates of mental illness, and certainly, that's reflected in some of the symptoms and in terms of addiction and incarceration. The suicide rates are three times higher. They're much higher for the north and remote communities, for Inuit and for males versus females. There is a shocking discrepancy between that and what the rest of Canada experiences.

**Tamara Jansen:** Yes, and we're definitely hearing from professionals that it's really a regional problem. In certain areas, you can get access, but in many areas, you can't.

I appreciate all of the work you're doing. Thank you.

**Roderick McCormick:** Thank you.

**The Joint Chair (Marcus Powlowski):** We'll go to Mr. Grant for five minutes.

**Wade Grant (Vancouver Quadra, Lib.):** Thank you, Mr. Chair.

I want to thank all the permanent members here for the work they're doing at this committee. It's a very important topic.

I thank the witnesses for coming forward.

Mr. Belanger and Dr. McCormick, my name is Wade Grant. I'm from British Columbia. I was formerly the First Nations Health Council chair, and I know that both of you have had interactions with the First Nations Health Authority. I grew up on a first nations reserve, where many of my relatives died way too young because of suicide and other things. We know that, far too often, first nations and indigenous communities will have to announce a state of emergency because of the overwhelming number of people, especially the young people, who are.... According to your stats, suicide is the number one cause of death for indigenous youth and those under 44. It's nine times higher for the Inuit community, three times higher for first nations and two times higher for Métis.

I grew up and went through that, and it shows that people are not getting the treatment they're searching for. You said this in your statement today, Mr. Belanger. I'm just wondering if you can explain a little more about how their needs are not being met or are being partially met and also what comes into play when people don't seek help because of the mistrust they've had for health care.

• (1955)

**Neil Belanger:** In a former life, I was the executive director of health for first nations in the north. We put in programs. We had an epidemic of suicide crises in the north in B.C. We worked with foreign nations to put together programs to try to address those things.

The unfortunate aspect is that funding within first nations communities is often inadequate to deal with mental health issues and to deal with home care. There's very limited disability-related funding that is provided, and access to clinicians is very difficult. You're looking at six months to a year or two longer in northern communities and sometimes even longer.

The distrust with government and government agencies still exists as well. Anti-indigenous racism in Canada has gone up exponentially over the last couple of years, and racism within health care is rampant. We know the cases of Joyce Echaquan and Keegan Combes. We know about the "In Plain Sight" report. There's all of this apprehension to go out and seek something—outside the community where your family is, where your supports are or where you are part of a community—in other communities and systems where you may not even be welcomed.

As has been noted, there are limited economic opportunities within communities and limited infrastructure. Some communities are dealing with massive housing problems. Again, the whole thing is the lack of availability of mental health services, and it's a struggle that has continued for a long time.

**Wade Grant:** Thank you, Mr. Belanger.

Dr. McCormick, you mentioned that indigenous rights are collective rights. Far too often, we look at individual rights. When I was on the First Nations Health Council, we issued the 10-year strategy on the social determinants of health, which was adopted by 84% of 176 chiefs back in 2023. We talked about the community-driven, nation-based approach. It's the "two-eyed seeing" approach for first nations to be able to make sure that the health and well-being of their people come home to them.

Maybe you can expand a bit on the work that you've done on that and how it's working when first nations' culturally sensitive and traditional ways of healing have been brought forward.

**Roderick McCormick:** There's been a growth of movement towards traditional healers, healing and ceremonies. A number of the health centres in B.C. have traditional healers as part of their staff. Ceremonies have been so valuable in people's healing. Those are being brought back. There's hope for the future, but a lot of it is what we have to do ourselves as indigenous communities. I'm a researcher, and I often say, "re-search is the search again for what we once knew", because we had some really good systems in place before colonization. We've tried for years now to get help from federal and provincial governments and organizations. A lot of money has been spent, but not a lot of help has been provided.

I believe that the secret is community empowerment, community engagement, ownership and self-determination in many ways when it comes to mental health services. Obviously, we're going to need some finances to do that, but we have to find the solutions ourselves, because government just hasn't been able to do it for us.

● (2000)

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

[*Translation*]

Mrs. DeBellefeuille, you have the floor for five minutes.

**Claude DeBellefeuille:** Thank you very much, Mr. Chair.

I'd like to thank the witnesses for their testimony.

Mr. Belanger, I'm a member who represents Akwesasne, the Mohawk community in my riding. Having been made aware by the grand chief, I know that there is indeed a lack of social and health services—not only for mental health, but across the broad field of health care—in the communities. Above all, there are substance use problems due to opioid addiction. These are very acute problems. We have discussed this in our area, in our community, and we deplore the fact that indigenous communities aren't better supported to deal with these significant health issues.

In all provinces, including Quebec, there is also a lack of funding and support in all health care sectors. That's why we would have liked to see today's economic statement include some new investments in health care for people who need it in the communities, as well as in provincial public services. We were disappointed to see that there weren't any. We have even been told that transfers to the provinces for health and social services will be reduced over the coming years.

I can't disagree with you that there's a lack of services, but we still have to address medical assistance in dying. I think you're using the word "euthanasia". I don't know if that's a misinterpretation, but in our clinical language, legally speaking, we're talking about medical assistance in dying, not euthanasia. Medical assistance in dying is a request that comes from an individual in their own right who chooses a way to die with dignity. There's palliative care, among other things. Medical assistance in dying involves a number of types of care. Lethal injection is just one type of care available as part of medical assistance in dying, so it isn't imposed. I don't see it as a type of care being imposed on a community, but as an option that individuals in their own right can accept.

I'll move on to my questions now. Forgive me for not having listened to all the previous testimony, since I'm not a permanent member of this committee, but I truly have a desire to better understand and learn.

Are there many people in your communities who have an incurable and persistent illness, such as cancer or multiple sclerosis? In your communities, do people turn to medical assistance in dying to relieve their suffering and die with dignity, or is it a type of care that you don't ask for because of your culture or your way of approaching life?

[*English*]

**Neil Belanger:** For our organization, and for me as the CEO, we deal with disabilities and with track 2. I don't know the frequency within the Gitxsan Nation or any nation of how many people might be requesting MAID or taking MAID under track 1. I haven't heard of any from my chief or the members in my family. It doesn't mean it doesn't happen, but I just don't have that expertise.

To go back, respectfully, I listened to your comments and appreciate them. I do, but medical assistance in dying is a euphemism that was put in place to.... It's non-culpable homicide in the Criminal Code. That's what it is. It is part of a process where we have indigenous and non-indigenous people with disabilities who are burdened and weighed down by pressures, from the lack of services you just described, to a point where they are making a decision that I believe is coerced. Even though people say it is a decision they make themselves, when you have all these pressures and everything else—

[*Translation*]

**Claude DeBellefeuille:** Mr. Belanger, I don't wish to be rude, but I have to interrupt you. Medical assistance in dying is currently unavailable to people with mental health disorders, so we can't talk about coercion. We're discussing the possibility of expanding access to it. Currently, medical assistance in dying exists for physical health problems, such as cancer, when the end of life is foreseeable.

The question I asked you was the following: Do people seek out this care in your communities?

● (2005)

[*English*]

**The Joint Chair (Marcus Powlowski):** You have a very short time to answer the question, Mr. Belanger.

**Neil Belanger:** Okay.

Again, under track 1, I couldn't give you that information.

**The Joint Chair (Marcus Powlowski):** Thank you.

We'll move now to Senator Dalphond for three minutes.

**Hon. Pierre Dalphond:** Thank you very much to the members of the panel.

First, Mr. Belanger, I recognize that you came before us in 2022. We worked together to have recognition of the Indigenous Disability Awareness Month almost 12 years ago. You've been involved in that for a long time.

When you appeared before us in 2022, you said that the federal government had not consulted with indigenous groups and nations before pushing for MAID. You said that you thought it was not really compliant with the UN declaration, or UNDRIP now. Have there been consultations between the Government of Canada or Health Canada and the indigenous groups since 2022?

**Neil Belanger:** There have. I think it began in 2023 or 2024. I'm not sure of the dates. Health Canada started to do an online consultation and provided some funding to different disability groups for indigenous perspectives on end-of-life care.

As I'm sure you know, Senator, it was on for a year. It had to be extended because of a lack of uptake. At the end of the day, they had 250 respondents from across Canada, 50 of whom they eliminated. In 2024 the population in Canada of those who identified as indigenous was 1.8 million, so the response rate was 0.001222%. I mean, I guess you could consider that a consultation. I don't know if it's that valuable.

We actually met with Health Canada in relation to that. We gave them a six-page document on our concerns about the online consultation. We had a meeting with them as well to address our concerns. I wouldn't say it was a productive meeting, but it was cordial. They offered us the possibility of a contract to do more consultations. We said that if we did that, then we would talk about the history of the AMAD committee. We'd talk about the recommendations. We'd talk about the implementation of MAID, including recommendations from mature minors and advance directives. I know that's not part of what we're looking at today, but we wanted to give the whole view for our communities and for the people we serve, so that they could have informed knowledge and could better answer questions on the survey than what had been provided. We never got a call back.

**Hon. Pierre Dalphond:** I'm sorry to interrupt, but there's almost no time left.

At the time, you were also stressing the fact that you had difficulty accessing mental health support. Has the situation improved for indigenous communities?

**Neil Belanger:** Do you mean in accessing mental health services?

**Senator Pierre Dalphond:** Yes.

**Neil Belanger:** I don't think so, no, not from our experience as a service provider.

**Hon. Pierre Dalphond:** Thank you.

**The Joint Chair (Marcus Powlowski):** Thank you, Senator Dalphond.

Senator Moodie, you have three minutes.

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

I'd like to thank you, Professor McCormick, for sharing your areas of research with us and helping us understand all the work you've done in the past. I would like to ask you one or two questions around this work.

First of all, in terms of helping me understand, would you agree that across indigenous communities, people hold quite a wide range of views on MAID—that in fact there are indigenous people who request, who have been found eligible and who have received MAID; that this is happening on reserve and in communities; and that there are indigenous MAID assessors and providers in Canada?

Are you aware, and would you agree, that this is the existing situation right now in indigenous communities here in Canada?

**Roderick McCormick:** Yes. As my colleague mentioned earlier, the report that was done looking at the experiences of indigenous people and MAID pointed out that a lot of people didn't know about it or had very little knowledge about it, so it was easy to get confused, I think. That was one of the findings.

Certainly, it does exist. I know of—

● (2010)

**Hon. Rosemary Moodie:** My question was about you and your knowledge. You are aware of this. Is that correct?

**Roderick McCormick:** Yes.

**Hon. Rosemary Moodie:** Okay. I'm just following up. You're aware that there are indigenous people and providers who believe that exclusion of MAID for mental illness alone is wrong, that they are being deprived of a service. Are you aware of that?

**Roderick McCormick:** I'm not aware of it, but that makes sense. As you say, there are a lot of diverse opinions.

**Hon. Rosemary Moodie:** I guess the final question I have is—and this is an easy day for you—have you done any specific direct research studying and consulting with any indigenous individuals who have wished to have MAID or with assessors or providers who provide the service? Have you done any population studies yourself? Is this an area of research that you yourself have intersected with?

**Roderick McCormick:** No, it isn't. I've done work in the past in looking at suicide recovery among indigenous patients, but not specifically for MAID.

**Hon. Rosemary Moodie:** Thank you.

That's the end of my questions. I cede my time.

**The Joint Chair (Marcus Powlowski):** Thank you, Senator Moodie.

Next is Senator Osler for three minutes.

**Hon. Flordeliz (Gigi) Osler:** Thank you, Chair.

Thank you to both witnesses for being here today.

My question is for Mr. Belanger. It follows on the questions that Senator Dalphond asked about consultations with indigenous communities.

I take it from your testimony that the level of consultation with indigenous communities was not sufficient. My question is, what measures would you recommend to the Government of Canada so that meaningful consultation with indigenous communities on extending MAID to persons with mental illness as a sole underlying medical condition meets the standards set out in UNDRIP?

**Neil Belanger:** UNDRIP called for the total repeal of track 2 MAID, including mental illness as a sole underlying condition, so there are no recommendations that I would make to anybody, because if we are going to be consistent with our international obligations, it should be removed. We wouldn't have to have a conversation.

My recommendation is that we provide quality, adequate and timely services to persons with mental illness as the sole underlying condition and to persons, indigenous people, with disabilities. That's the only recommendation I can make. I can't make recommendations where irremediability is so divided among clinicians and say, “How do we make this more culturally appropriate and how do we make it fit for your community?” It wouldn't make sense to do that.

We need to act upon the recommendations of the UN. We need to repeal this, including mental illness as a sole underlying condition, and get people the support they need to thrive in their communities, without exception. There are multiple areas that have to be addressed. It's not just access to mental health services. It's housing. It's conditions of poverty. It's isolation.

It's all of those things that I'm saying are stacked up and stacked up.... No, there's nothing I would say that could make this...where I would say that I would want to see this be a reality.

**Hon. Flordeliz (Gigi) Osler :** Just so I'm clear, you're saying that there should be no further consultation at this point.

**Neil Belanger:** Well, I'm saying that I'm hoping this committee will make recommendations—based upon what the UN has said, based upon information from the last committee and based upon information we've heard here—that we'll honour the UN and our obligations to them and make recommendations to repeal track 2 MAID, including mental illness as a sole underlying condition.

I can't make recommendations on things in the future. We have to see what the recommendation from this committee is going to be and what we're going to do moving forward. Then I can make recommendations, but it will never be to euthanize individuals dealing with mental illness as a sole underlying condition or persons with disabilities when their basic needs aren't being met. Also, that shouldn't be, respectfully, anything that this committee should be endorsing.

We need to deal with the problems that are here today and the deficiencies within the systems. This is nothing new. This is a fight that we've been doing for years, as have other organizations. The reward for living a life of inadequacy and lack of access to services shouldn't be what people describe as a “dignified death”. We need to have dignified lives, where people get the support they need to thrive.

**The Joint Chair (Marcus Powlowski):** Thank you, Mr. Belanger.

Next is Senator Wells for three minutes.

**Hon. Kristopher Wells:** Thank you.

My question is for Dr. McCormick.

Could you clarify for me? I'm not sure I heard correctly when you did your introduction. Are you with Indigenous Disability Canada?

● (2015)

**Roderick McCormick:** No. I'm a professor at Thompson Rivers University and a research chair.

**Hon. Kristopher Wells:** Thank you for clarifying that.

Maybe I'll go back to our witness.

I think you've already clarified some of this. Your position is that track 2 should be fully eliminated.

**Neil Belanger:** My position is that any law that targets a charter-protected group should not be on the books.

**Hon. Kristopher Wells:** Is your organization a plaintiff in the charter challenge to track 2 currently?

**Neil Belanger:** We are.

**Hon. Kristopher Wells:** Thank you.

Dr. McCormick, I think it's safe to say that everyone at this table agrees that every Canadian should be provided with adequate supports, whether they're financial or emotional, to help them deal with mental illness. However, a majority of the witnesses at this committee have made the false equivalency between requesting MAID and having suicidal ideation. Being approved for medically assisted death and having suicidal ideation are two different things.

Dr. McCormick, if somebody who has a mental illness is genuinely seeking MAID or additional information on the MAID process, how do you suggest suicide prevention frontline workers address these questions?

For the record, I want to point out that to receive a medically assisted death in Canada, a person has to be eligible under strict rules laid out under the law, and they have to go through a rigorous process by multiple medical professionals to be deemed eligible.

**Roderick McCormick:** On the last part you said—and I don't have data in front of me—from what I've read, the safeguards just aren't there. Perhaps you can correct me, but my understanding is that people can choose whether they've exhausted the options for treatment. They can make their own decisions and can say, “No, I don't want any of the talking therapy, or this or that.”

I work in the field with trauma recovery. There are so many new options out there, like EMDR, psilocybin-assisted psychotherapy.... We're coming up with new approaches all the time.

**Hon. Kristopher Wells:** If somebody comes to your organization for suicide prevention and inquires about MAID, how do you suggest your frontline workers address these questions?

**Roderick McCormick:** My field is in counselling psychology. We would spend a lot of time talking to that person about different options. It would be a lengthy process. It varies, in terms of MAID assessors, as to how much time is spent finding out the person's story and what they have and haven't tried, what their resources are, and what their threats and protective factors are. There's so much that goes into working with someone who wants to die.

**Hon. Kristopher Wells:** Would you refer them to indigenous MAID providers?

**The Joint Chair (Marcus Powlowski):** Senator, your three minutes are up. Thank you.

We will go to the second round of questioning, with Mr. Patzer for three minutes.

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

Before I begin, Mr. Chair, I want to highlight that I think it's completely inappropriate for Senator Wells to call people he disagrees with liars at this committee, when we have had—

**Hon. Kristopher Wells:** On a point of order, I did not say those words.

**Jeremy Patzer:** Yes, you did. You said that the majority of witnesses of this committee were lying in regard to suicidality—

**Hon. Kristopher Wells:** [*Inaudible—Editor*]

**The Joint Chair (Marcus Powlowski):** Mr. Patzer is using up his three minutes as he pleases. He is on the clock.

Go ahead, Mr. Patzer.

**Jeremy Patzer:** Thank you, Mr. Chair. I will let my comments stand.

Mr. Belanger, in regard to your comments about the United Nations, has Canada formally responded to the recommendation you were alluding to?

**Neil Belanger:** They haven't, no.

**Jeremy Patzer:** We've been hearing from witnesses about the Werther effect and suicide contagion. We have responsible reporting guidelines for media coverage of suicide, which people in the entire field of suicide prevention follow.

What is the contagion risk in indigenous communities, specifically when government legislation says death is a valid medical response to mental illness?

**Neil Belanger:** I think it's quite high.

I'll go back to my life working in the health sector and dealing with the suicide crisis we went through. We worked with four different nations, because they were experiencing similar things. One of the nations said that they were no longer going to have celebrations of life, because it highlighted the person's suicide. Youth and other people in the communities would do that because they saw it as a celebration—people getting together and recognizing that person—so they said they wouldn't do that anymore.

Track 1 and track 2 get intertwined all the time. The stuff you see online, where people say, “I was there, and I was drinking champagne and doing whatever,” is not the reality for most people and persons with disabilities living in poverty. However, it gives a message that this is a good escape, the way to go, and that this is some kind of justification that the end is somehow dignified after a life of wanting but not having supports. I don't think that's true, but I think it certainly influences them, to be sure.

● (2020)

**Jeremy Patzer:** Thank you for that.

We've now sat through about three years' worth of these committees.

What do you want this committee to put in its report so that, two years from now, we're not back at this table asking why more indigenous people with disabilities or mental illness have died because we expanded a system that we knew was broken?

**Neil Belanger:** I would hope the committee says, “We've taken a look at this, and we've looked at the law.”

It's targeting persons with disabilities and individuals with mental illness as a sole underlying condition. Look at the spring economic statement today and the lack of services and funding in that as well. If we have to make changes in Canada, we have to make sure we're supporting people with disabilities and individuals with mental illness as a sole underlying condition.

This is not a progressive move. It's not an equality right. It's ignoring our responsibilities to our most vulnerable. We're normalizing this. Once it becomes more normal, we will never get it back. We know government will come back and say, “Oh, let's make sure they're radically funding this,” because it has become an acceptable alternative to proactive, timely and adequate treatments, with supports and services. This is where we are today. We need to stop it, because if it keeps going forward, it's not going to stop. We've seen laws in the past that have been on the books for 50 years, wherein indigenous people were targeted and things happened. It took 50 years to get past it. Even then, after they came off the books.... We're dealing with them today. We shouldn't be in this situation. Take it back and give the support to people in need.

[*Translation*]

**The Joint Chair (Marcus Powlowski):** Mrs. Brière, you have the floor for three minutes.

**Hon. Élisabeth Brière (Sherbrooke, Lib.):** Thank you very much, Mr. Chair.

Welcome to both witnesses.

Mr. Belanger, I heard your answer to the previous question, and I agree with you that there are certainly a lot of things we can work on to improve people's daily lives. We can improve access to care and housing conditions, for example.

When someone requests medical assistance in dying, do they automatically get it?

[*English*]

**Neil Belanger:** I'm sorry. Do you mean, get MAID automatically?

**Hon. Élisabeth Brière:** Yes. If you ask for MAID, do you think you will automatically get it?

**Neil Belanger:** It depends on what track you're doing. Under track 2, there's a 90-day waiting period. During that time, there's an assessment period for the person, so they can think about it. Hopefully, they're getting programs and services or being recommended to different disciplinary supports, but that really doesn't happen. That's the thing. In my case, about the individual being approved for MAID but not even being referred to get their disability tax credit....

I don't think it happens immediately. In some cases, lines can be—

**Hon. Élisabeth Brière:** I'm sorry. I'm not talking about a span of time.

I'm asking you this: If someone asks for MAID, do you think they will get it?

**Neil Belanger:** Do you mean, if somebody requests MAID, do I think they'll get it automatically?

**Hon. Élisabeth Brière:** Yes.

**Neil Belanger:** I would hope not. I don't think that happens.

**Hon. Élisabeth Brière:** Do you think they will?

**Neil Belanger:** No. If you walk in and ask for MAID, I don't think you will automatically get it.

[*Translation*]

**Hon. Élisabeth Brière:** Okay.

In that case, I'd like to hear what you have to say about the integrity of medical assessors who analyze a case and give their approval—or not—to a request for medical assistance in dying.

[*English*]

**Neil Belanger:** I'm not a clinician, in any sense. I would defer to the clinicians who spoke here, both those who are for it and those who are against it.

There's no consensus on it. If there's no consensus.... I'm not sure what percentage would be acceptable. Maybe 80% think it isn't irremediable. Is it 40%? What's the acceptable number of people who might be euthanized but who could have had a better life? For me, it's zero. Unless there's 100% agreement on this, we are running the risk of euthanizing people who could have led a good life. That's not a risk I would take, personally, because I know the damage it does to families and how everyone has to go through this.

I'm not debating the credibility of the clinicians, but the fact that they are so divided should give this committee pause, so that it says, “What are we talking about? There's no consensus here, so how can we push forward or expand a law on something nobody can agree on?” It's not like—

● (2025)

**The Joint Chair (Marcus Powlowski):** Thank you. We have to move on.

**Neil Belanger:** Thank you.

[*Translation*]

**The Joint Chair (Marcus Powlowski):** Mrs. DeBellefeuille, you have the floor.

**Claude DeBellefeuille:** Thank you, Mr. Chair.

Mr. Belanger, pardon my ignorance on the indigenous issue, but I'm curious by nature and want to understand and learn.

When you speak, you represent your group, but I'd like to know where the demand you expressed—to exclude indigenous communities from medical assistance in dying—comes from. Is that a motion or a decision by all first nations and Inuit communities? Is that a demand that's currently being pushed on the government, or is it more your opinion as a representative of the group you're here on behalf of today?

As a member of Parliament, my grand chief has never approached me or contacted me to discuss this desire to exclude his community.

Are all nations, including the Inuit, making this request?

[*English*]

**Neil Belanger:** I don't speak for all first nations. I don't speak for any first nation. I don't speak for any of the 53 Inuit communities. I speak for our organization and our experience with the people we serve, who are indigenous people with disabilities. Our perspective is, of course—

[*Translation*]

**Claude DeBellefeuille:** Forgive me for interrupting you, but it's important for me to understand whether it's your opinion and that of your organization or a request from first nations and Inuit that you're relaying to our committee. Thank you for your answer.

Professor McCormick, I wanted to know whether there are people in indigenous communities asking for medical assistance in dying, which is currently legal, but Mr. Belanger didn't have any data to share with me. Do you have any figures? Is there a trend? Are indigenous people using this care, which is available and legal?

[*English*]

**Roderick McCormick:** No, I don't have it. I'm not sure if that data is available. It should be, but I don't have it.

[*Translation*]

**The Joint Chair (Marcus Powlowski):** Thank you very much, Mrs. DeBellefeuille.

[*English*]

We now have Senator Moodie for two minutes.

**Hon. Rosemary Moodie:** I want to ask Professor McCormick this. Do you have any data whatsoever that sheds light for us on what is happening with the use of MAID in your communities more broadly?

**Roderick McCormick:** No, I haven't researched it. I've read the report that was done, the consultation. That's the data I have. Again, it was one city per province that was surveyed.

**Hon. Rosemary Moodie:** You're not uniquely in a position where you can judge the validity or have a comparative basis for this particular type of data. You've read it as I have or anybody else has. Would that be true?

**Roderick McCormick:** That's correct.

**Hon. Rosemary Moodie:** Is it reasonable to say that you bring a certain expertise today to this committee, but it does not relate directly to MAID or to the use of MAID in communities?

**Roderick McCormick:** I bring 40 years as a clinician working with indigenous people who are experiencing mental illness. That's what I'm bringing to this committee.

**Hon. Rosemary Moodie:** You don't have a direct connection with mental illness to MAID, though, because you aren't able to give us the information of what that connection might be.

**Roderick McCormick:** I don't—

**Hon. Rosemary Moodie:** Maybe I'm not clear in how I'm asking for it. Do you have a connection?

**Roderick McCormick:** No, I don't have that data. I don't even know if it's available.

**Hon. Rosemary Moodie:** Thank you.

**The Joint Chair (Marcus Powlowski):** We have Senator Wells for the final two minutes.

**Hon. Kristopher Wells:** Mr. Belanger, the Health Canada report published in December 2025, entitled "Indigenous perspectives on end-of-life care, including medical assistance in dying: What we heard", reported hearing the following from elders of first nations, Inuit and Métis people:

> We need to reclaim our death and end-of-life processes.
>
> When our loved ones die, we should have the right to bring them home.
>
> I fear losing the ability to decide for myself.
>
> It is concerning that there is a lot of misinformation about MAID.

Mr. Belanger, I agree that colonialism in Canada's systemic exclusion of indigenous people has led to unacceptable rates of suicide in indigenous communities. If this is what we're hearing, what I quoted to you from the Government of Canada from indigenous people themselves, how should we then balance these points of view with the removal of MAID track 2 that you suggested here today?

● (2030)

**Neil Belanger:** Well, I'd like to know, is it from the 200 people who responded to the survey?

**Hon. Kristopher Wells:** It's from the Health Canada consultation they did.

**Neil Belanger:** It could be 200 people out of a population of 1.8 million.

Again, as we've heard, I'm not denying that there may be people in the community who are supportive of track 2 MAID or MAID, but if you'll remember from the previous committees, the majority of the indigenous witnesses, the leadership and persons with disabilities all spoke against it. I can't comment on a survey of 200 people out of a population of 1.8 million to say this is some kind of tangible document that we have to reinforce.

**Hon. Kristopher Wells:** You don't think the document produced by Health Canada is credible?

**Neil Belanger:** I think it's lacking.

**Hon. Kristopher Wells:** Okay.

**Neil Belanger:** I think the government should do nation-to-nation consultation, as it's supposed to do, to get a good idea about that.

**Hon. Kristopher Wells:** Do you feel that we should, at this committee, have perspectives from indigenous people who would like access to MAID?

**Neil Belanger:** I think this committee should call any witness they think is relevant.

**Hon. Kristopher Wells:** Thank you, Chair.

**The Joint Chair (Marcus Powlowski):** Thank you.

With that, I'd really like to thank the witnesses for bringing an interesting cultural perspective to this conversation.

The meeting is adjourned.

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