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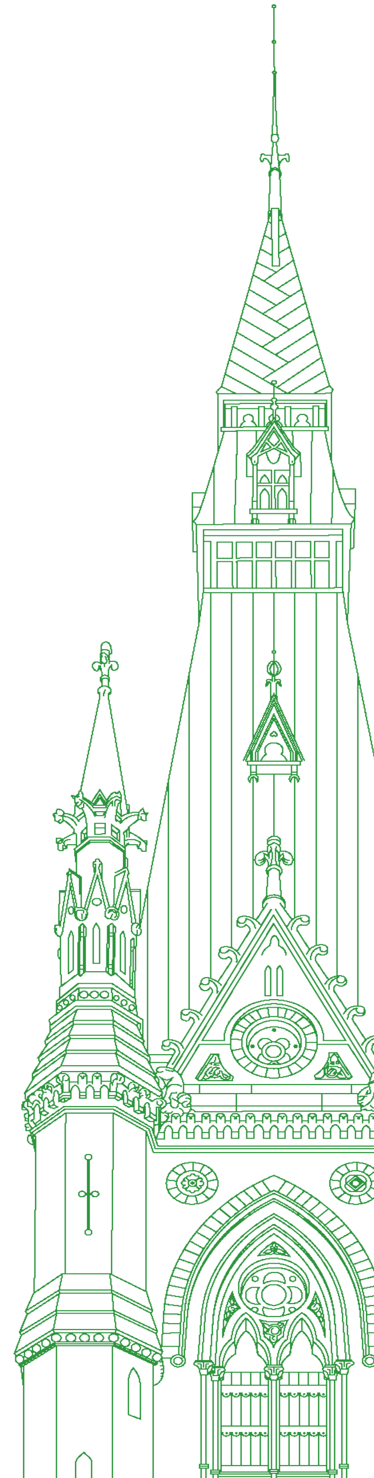

Co-Chairs: Marcus PowlowskiYonah Martin

Special Joint Committee on Medical Assistance in Dying

Tuesday, May 5, 2026

● (1835)

[*English*]

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

Welcome to meeting number seven 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 of 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 would like to confirm that the sounds tests were done successfully.

Before we continue, I will ask all in-person participants to consult the guidelines written on the cards on the table.

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

First, 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 are not speaking.

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

This is a reminder that all comments should be addressed through me, 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, and we appreciate your patience and understanding in this regard.

Before we begin, I'll remind you that for the last hour today, we will meet in camera to give drafting instructions to our analysts for our report.

Now, we welcome our witnesses today. All of them are joining us all the way from Holland.

I believe you may have a World Cup team that's coming over here. Until then—until we actually oppose each other on the field—we're friends.

I would like to welcome Dr. Jim van Os, professor of psychiatry; Dr. Wilbert van Rooij, another psychiatrist; and Dr. Sisco van Veen, yet another psychiatrist. I'm sorry. That's all the information they sent us.

Try to finish your remarks within five minutes. I will hold up a piece of paper—I don't know whether you'll be able to see it—when there are about 30 seconds left.

To begin, we have Dr. van Os for five minutes, please.

Dr. Jim van Os (Professor of Psychiatry, As an Individual): Thank you very much, honourable committee members, for inviting me.

I am a professor of psychiatry at the Utrecht University Medical Center and a fellow of King's College in London. I advise the Dutch government on the current transition of our mental health services. In that capacity, I lead social trials of a new form of mental health care in a direction that bears directly on the question before this committee.

The Dutch experience, in my opinion, offers a warning for Canada. For 20 years, our euthanasia law left psychiatric cases largely untouched. However, over the past decade, a small group of activist physicians and organizations built a practice through sustained media campaigns. In 2024, the Dutch expertise centre for euthanasia received around 5,000 requests, with roughly 1,000 on psychiatric grounds. Among people under 30, requests rose from about 30 per year to nearly 900 in six years, and completed euthanasia rose fivefold. This pattern has been widely interpreted as a so-called suicide contagion effect, which is amplified by the institutions that should safeguard against it.

Here is a contrast that this committee should perhaps keep in mind. Under Dutch law, physicians must agree that there are no reasonable options. Euthanasia is, in principle, the very last resort. Canadian law does not work this way. In Canada, patient choice trumps the physician's professional judgment, so a doctor cannot insist that other options be tried first. That single difference will, in our assessment, drive Canadian numbers beyond ours.

In 2024, the UN Committee on the Rights of Persons with Disabilities warned that the Dutch practice was unsafe. Persons with psychosocial disabilities have a fundamental human right of protection against premature death. Euthanasia for mental suffering cannot be cleanly separated from physician-performed suicide. It is, in many cases, suicide carried out by a psychiatrist.

Our research and clinical work reveal a minefield on every side.

On autonomy, most people who request euthanasia for mental suffering are traumatized, marginalized and often living in poverty without prospects. Mental illness, by definition, compromises autonomy. Calling such a request a free expression of choice ignores the substance of the suffering.

On discrimination, the argument that refusing euthanasia for mental suffering is discriminatory equates psychiatric suffering with terminal cancer. It is a false equivalence. Cancer with a two-month prognosis is linear and progressive. Mental suffering is not. Recovery happens, often unexpectedly, through relationships, purpose, meaningful work and bonding with another person or even an animal. The patient-led recovery movement insists that recovery is possible for everyone. Plasticity is the rule.

On criteria, clinicians do not agree on irremediability, futility or competence. The result is something like a lottery. Whether you receive suicide prevention or a lethal injection depends on which clinician you meet.

On substance, recent Dutch analyses show that many who receive euthanasia are women with unaddressed trauma. Their unconscious self-destructive dynamics get enacted in the procedure. The psychiatrist becomes recruited into a deadly outcome. Tuffrey-Wijne and colleagues describe how in the Netherlands, people with autism spectrum traits increasingly receive euthanasia for what is, at its root, social suffering framed in medical language. The intervention should be social and existential, not lethal.

Psychiatry claims it can both prevent suicide in one patient and help finalize suicide in another with the same suffering. That is incoherent. It is not autonomy. It is not anti-discrimination. It is a contradiction at the heart of our profession.

● (1840)

My message to Canada is this: Do not expand. The evidence is not there. The UN, the International Association for Suicide Prevention and our lived experience point the same way. The social trials that we ran in the Netherlands show another path: care that builds relational continuity, hope and connectedness. That is the system worth building, not procedural pathways to death.

Thank you.

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

Next is Dr. van Rooij.

Dr. Wilbert van Rooij (Psychiatrist, As an Individual): Thank you, Mr. Chair.

Honourable committee members, thank you for inviting me. I'm a Dutch psychiatrist. For nearly 30 years, I've worked with people with severe psychiatric disorders. In that time, I've seen mental health services in the Netherlands steadily erode, especially for those with the most complex conditions. This deepens despair and may contribute to a wish to die in some patients.

Since euthanasia was legalized in 2002, psychiatric euthanasia or MAID has gradually become normalized in the Netherlands. This trend has rapidly accelerated in the past decades.

In my practice, I now meet more vulnerable, often relatively young, patients who are, in principle, treatable. However, they request euthanasia because timely and adequate care for them has been eliminated for political and economic reasons. At the same time, a small group of activist physicians has adopted an increasingly permissive approach to MAID, often justified in the language of autonomy and compassion.

In 2024, with several colleagues, I raised the alarm about how broadly the legal due care criteria are being interpreted in psychiatric cases. The resulting debates revealed deep division and a lack of consensus among Dutch psychiatrists.

I speak today, out of care and responsibility, to warn of the dangers when structural shortages in mental health care and ideological convictions begin to shape decisions about life and death for some of the most vulnerable people in our society. Allow me to frame this with a story older than any of our laws.

When the Greek hero Odysseus finally sailed home, he was exhausted and wounded after years of war in Troy. On the last stretch, he faced the sirens, voices promising peace and an end to suffering. He knew that if he listened freely he would perish, so he asked his crew to bind him to the mast, not because he was weak but because he understood that the urge to escape pain can peak precisely when judgment is most vulnerable.

As a clinician, that image returns to me when I consider euthanasia for psychiatric patients. I have sat with many people who are tired in this Odyssean way, worn down by chronic depression, trauma or personality disorders. When they say to me, “I don't want to live anymore,” in most cases they are not asking to die. Often they are asking for pain to stop, for meaning to return and for someone to not give up on them.

For doctors, the central question can shift from “Is there still hope?” to “Have we followed the steps?” Suffering becomes something to be assessed, documented and, ultimately, validated by death.

Psychiatric euthanasia increasingly involves young people with conditions that fluctuate over time. These are not terminal illnesses; they are lives with uncertain trajectories. Euthanasia requires certainty, irremediable suffering. In psychiatry, that certainty is often an illusion. Moreover, vulnerability is not evenly distributed. In the Netherlands, women, young adults and people with trauma histories, autism, intellectual disability or personality disorders are overrepresented among those requesting and being granted psychiatric euthanasia. These are often people whose agency has been eroded by life experiences. To call this pure autonomy is clinically naive.

As a psychiatrist, I am trained to tolerate despair without endorsing it, to stay present and still say, “I don’t know the answer yet, but I am not done with you.” That stance is not paternalism. It's fidelity. It's what kept Odysseus alive until the voices had passed.

● (1845)

Canada now stands at a similar narrow strait. If you extend euthanasia to psychiatric suffering, you will not simply add an option. You will reshape the moral landscape of care.

You ask clinicians to decide not only when life can no longer be cured, but when it no longer should continue. That is a burden psychiatry was never designed to carry.

I ask you to pause to listen not only to legal arguments but to clinical experience, to those who have seen safeguards stretch, criteria soften and procedure replace presence.

Binding ourselves to the mast is not cruelty; sometimes it's the most humane act we have. Please do not ask psychiatrists and doctors to become the sirens for people who need our compassion, care and protection.

Thank you, Chair.

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

Dr. van Veen, you have five minutes.

Dr. Sisco van Veen (Psychiatrist, As an Individual): Thank you for inviting me.

I'm Sisco van Veen. I am a psychiatrist from the Netherlands who is experienced in assessing psychiatric MAID requests.

As an empirical ethicist, I have been studying MAID for psychiatric suffering for 10 years now, and I am currently the head of the end-of-life psychiatry research group at the Amsterdam University Medical Center. I also have a research appointment at our national suicide prevention centre, and I’m the chair of the committee tasked by the Dutch Psychiatric Association with updating the clinical guidelines for psychiatric MAID.

I have been following the debate in Canada closely over the past years, but as a disclaimer, I would like to state that I've learned that when it comes to this topic it is virtually impossible to maintain a detailed understanding of another country's legal, cultural and ethical context, because it's continuously shifting. For the remainder of my time I'll focus on the Dutch situation and what universal lessons can be drawn from that.

MAID for psychiatric suffering has been legal in the Netherlands for decades, first, on the basis of jurisprudence, which was codified into law in 2002. Our first guideline for psychiatric MAID stems from 1998 and describes a rigorous assessment procedure. However, in clinical practice, it remains extremely rare. Only zero to five cases were reported annually, and it was barely a topic for patients and clinicians alike.

This changed around 2010 when the possibility to request MAID for psychiatric suffering became more salient. A few years later, the Expert Centre on Euthanasia, ECE, was formed, which quickly became the centre where most patients with psychiatric MAID requests were referred to.

With this, the cases started to increase over the years, about 8% annually until 2024. This is a significant raise, but it's also important to mention that psychiatric MAID to this day remains relatively rare at around 2% of all MAID cases.

The increase in cases eventually led to long waiting lists at the ECE, which in turn was reason for a small group of pro-MAID psychiatrists to seek publicity and call on their colleagues to perform psychiatric MAID more often.

In my view, this mainly caused a strong resistance among Dutch mental health care professionals, which in turn was fertile soil for a fierce and equally public counter-reaction, deepening the polarization further. This dynamic has soured the debate and may have contributed to the 21% drop in psychiatric MAID cases we saw in 2025, which in itself, of course, cannot be seen as a bad thing.

Together with different stakeholder groups, including the Dutch Psychiatric Association and the Dutch Patients’ Federation, we are currently working on getting the discourse back on track in the Netherlands to a more nuanced and constructive conversation. This is important for there are still many clinical and ethical challenges that require our continuous attention, which I’m happy to discuss further if asked.

Let me continue with my more universal, moral view on psychiatric MAID. Drawing on a decade of clinical and research experience, I've come to the following view. Although respecting autonomy is, of course, a fundamental justification for MAID, mercy is even more important. Because of this, I think it's hard to justify excluding patients with psychiatric disorders whose suffering can be immense or, in other words, unbearable.

I do think that MAID for terminal suffering is fundamentally different from MAID for chronic suffering. MAID for terminal illness is a way to prevent a terrible death, and MAID for chronic illness can be seen as a way to end a terrible life. Both situations require different due diligence approaches, and I think your two-track system reflects this better than our Dutch system, which does not make this distinction.

I also think MAID should be accessible for people suffering from chronic illness, because, by definition, death will not end a suffering that is not terminal. Although I see a lot of differences between chronic physical and psychiatric suffering, I do not think these differences are sufficient to justify a complete ban of psychiatric patients. Uncertainty about irremediability is a big challenge in almost all cases regarding psychiatric suffering, but it can also be an issue in some forms of chronic physical suffering.

I would also argue that adopting a retrospective view on irremediability is more suited for patients with psychiatric and chronic physical illness. This means that a physician isn't asked to judge whether a patient will never recover, but that the physician is asked to judge, together with the patient, if they have suffered enough.

Finally, I have a short word on media dynamics.

● (1850)

It is my experience that media and social media play a profound, polarizing role in debates surrounding psychiatric MAID. This worries me a great deal. For large groups in both our countries, this is not a mere theoretical, ethical problem. It's a debate with real-life concerns of real people who are in vulnerable positions. These people deserve that we remain curious about each other's viewpoints and commit ourselves to a respectful, responsible and constructive debate.

Thank you for your invitation to contribute to this conversation.

I'm happy to answer all your questions.

The Joint Chair (Marcus Powlowski): Thank you to all the witnesses.

We'll start the first round of questioning with Ms. Jansen for five minutes.

Tamara Jansen (Cloverdale—Langley City, CPC): No, I think it's Mr. Cooper.

The Joint Chair (Marcus Powlowski): It's Mr. Cooper. I got this totally wrong.

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

I'll start with Dr. van Os.

Professor Jocelyn Downie from Dying with Dignity Canada claimed at this committee that, if there is a delay or indefinite pause on the expansion of MAID for mental illness, people will die by suicide, impliedly asserting that MAID for mental illness will reduce suicide rates, but empirical data doesn't demonstrate that, does it?

Dr. Jim van Os: You are correct. At the population level, there is not a correlation or an inverse correlation between euthanasia and suicide rates in different countries with different levels of both these practices. Also, at the individual level, it's not possible to say that euthanasia is necessary to prevent suicide, because even in patients requesting euthanasia, the rate of suicide is very low. You have a number needed to treat of 10, and a number needed to harm of nine, meaning that 10 young people must undergo euthanasia to prevent one suicide, and nine die without any preventive purpose being served.

● (1855)

Michael Cooper: In short, such an intervention would result in far more deaths than it could possibly save.

Dr. Jim van Os: Yes, that is correct. I published this in the British psychiatric bulletin last month.

Michael Cooper: Looking at the experience in the Netherlands, you noted that there has been a substantial increase in MAID cases where mental illness is the sole underlying condition in recent years. I thought you had said there had been a fivefold increase. Is that right?

Dr. Jim van Os: It's a fivefold increase in those under 30 years of age.

Since 2020, there has been a 200% rise in psychiatric euthanasia cases compared to a 40% rise in total euthanasia cases in the Netherlands.

Michael Cooper: A disproportionate number of those cases involve women. Do I have that right?

Dr. Jim van Os: Yes. This is seen in many countries. Women are far more likely to request euthanasia for psychiatric reasons than men.

Michael Cooper: Despite a growing number of MAID cases, the suicide rate among women, particularly young women, has gone up, not down, in the Netherlands. Is that correct?

Dr. Jim van Os: That's correct, yes. There's a tendency for it to go up and not down.

Michael Cooper: Thank you.

I'll move to Dr. van Rooij.

You spoke about vulnerability not being evenly distributed, and that women, young adults and persons with trauma histories, autism and personality disorders are overrepresented among those who seek MAID where mental illness is the sole underlying condition. Can you elaborate on the experience in the Netherlands with respect to vulnerable populations?

Dr. Wilbert van Rooij: Yes. Thank you, honourable committee member, for this very important question.

There have been some studies by our official bodies installed by the government who are keeping statistics of the people who receive euthanasia solely on the basis of medical grounds, and a lot of patients being granted euthanasia come from certain groups, as I mentioned. The foremost is women, young women. People with autism are on the rise. There's a very big population of autistic patients asking for and being granted euthanasia in the Netherlands.

Also worrying is what came from the British research from Professor Tuffrey-Wijne in London. She revealed that, in many cases, even intellectual disability is not an exclusion criterion anymore for receiving euthanasia. That's particularly worrying, because when you read the statements the doctors gave to justify these euthanasias, they are quite worrying.

Professor Tuffrey-Wijne, who's of Dutch descent, by the way, was quite shocked when she read those reports by the body that does the supervision over the euthanasias. She said, for example, that a lot of patients receive euthanasia not based on any medical condition or something, but mainly on the basis of their social position, of situations like demoralization or a lack of social integration in society.

The Joint Chair (Marcus Powlowski): Thank you, Dr. Rooij. We've run out of time for that round of questioning.

Next is Mr. Fergus for five minutes.

[*Translation*]

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

I appreciate the opportunity to speak.

Before I ask the witnesses my questions, I just want to ask you one question. Perhaps the clerk can answer it as well.

Earlier today, I received a letter that the minister of health and minister responsible for seniors and caregivers wrote to her federal counterpart. In that letter, she concludes that Quebec isn't in favour of expanding access to medical assistance in dying to persons whose sole medical condition is a mental illness. The letter reads as follows: “Finally, the report also cited concerns about the difficulty of properly diagnosing mental disorders and the worries of many health and social services professionals that the therapeutic relationship with their patients would be complicated if MAID were expanded to mental disorders alone.”

Will this letter be included in the testimonies taken into consideration by the committee?

● (1900)

The Joint Chair (Marcus Powlowski): Perhaps the analyst can answer your question.

The Joint Clerk of the Committee (Jean-François Lafleur): Thank you, Mr. Chair.

We received this letter on Monday. The letter is in French. The letter will be translated according to the rules set by the committee and then distributed to each of its members. They can decide what to do with the letter.

Hon. Greg Fergus: I would like to know whether this letter will be included in the testimonies that we received or in the documents that we can quote when drafting the report.

The Joint Clerk (Jean-François Lafleur): This letter was received in response to Mrs. Jansen's motion, which was passed and which ordered the production of documents. This letter was received in response to that order. Again, the letter will be translated. If the committee sees fit to include this letter, it can do so, obviously.

Hon. Greg Fergus: Okay. Thank you.

[*English*]

Thank you to our witnesses today. I have a couple of questions.

Dr. van Os, you made some very strong statements, one of which is that the question that is before us is the equivalence of “suicide carried out” by psychiatrists. I'm wondering if you could, given your experience in the Netherlands, please explain why you would consider that to be a fair comment to make, or is it an exaggeration?

Dr. Jim van Os: This is not a strong statement. This is, in fact, a well-known framing of the problem. It is often virtually impossible in clinical practice to distinguish between the symptom of suicide and the death wish expressed in the form of a euthanasia request.

The International Association for Suicide Prevention has attempted to come up with a statement trying to guide clinicians to distinguish between a death wish as a symptom of mental illness and a death wish as a rational expression of euthanasia. In theory they may exist, but in clinical practice they are very difficult to distinguish from each other.

Therefore, what often happens is that individuals indeed suffer and express a death wish as a result of their mental suffering which results from a mental disorder. They are granted euthanasia, so the doctor performs the suicide. This is not a strong statement. This is an internationally accepted framing of the question before us.

Hon. Greg Fergus: I have very little time left.

Dr. Rooij, you had pointed out a case in the Netherlands, which has had this available for about 30 years. You said that mental health services were not equally distributed and that would therefore affect whether or not you were able to make the case for irremediability.

Could you talk a little more about that from a Dutch experience?

Dr. Wilbert van Rooij: Thank you for that very important question. In essence, it's a more political question than a medical question.

What I witnessed in the last 30 years is that psychiatric care, especially for the people most severely affected by mental suffering—like the population I mentioned earlier, the people with autism, personality disorders and traumatic histories—has been selectively reduced in the Netherlands.

Our health care system, which is a commercial system, is run by health care insurance companies. For health care insurance companies, providing care for the most severely psychotic ill patients is not very profitable.

In the last 15 years, this care in the Netherlands has been reduced quite significantly. The patients I could treat 20 years ago quite adequately and effectively are now perishing on long waiting lists. These waiting lists are getting longer and longer in the Netherlands. Many patients come to me, or sometimes even their parents or family members, saying, "If this system can't provide proper care to my loved one, I at least ask you, as a doctor working in that system, to be able to provide euthanasia to this person, to this family member, because you can't provide any care anymore."

That's causing a lot of moral stress in Dutch psychiatrists, as you can understand. This has made quite an impact on many psychiatrists I speak to on a daily basis. They are very reluctant and very wary about what's happening now in our country.

We have to be quite clear that people die now, who could have been treated 10 to 20 years ago quite effectively. I've done it myself. It's actually a real shame.

● (1905)

Hon. Greg Fergus: Thank you.

[*Translation*]

The Joint Chair (Marcus Powlowski): Mrs. DeBellefeuille, it's your turn now. I see that you're sitting on the other side of the table this evening. Have you changed parties?

Claude DeBellefeuille (Beauharnois—Salaberry—Soulanges—Huntingdon, BQ): Just for the evening.

Voices: Oh, oh!

Claude DeBellefeuille: Thank you, Mr. Chair.

I'll make a comment.

I appreciated our witnesses' testimonies. However, I find it odd that we could meet with psychiatrists from the Netherlands, whereas we couldn't meet with representatives of the Canadian Psychiatric Association to ask them questions. I'm not a permanent member of the committee. Frankly, I find it hard to understand why we're speaking with people from the Netherlands when we can't consult our own psychiatrists, who have an opinion. I wonder whether the representatives of the chair or the clerks are responsible for the fact that we haven't heard from them, given that the study ends this evening. Mr. Chair, I must say that I find this unacceptable.

[*English*]

Tamara Jansen: On a point of order, I want to make sure we recognize that we've heard from many psychiatrists and psychiatrist associations.

[*Translation*]

Claude DeBellefeuille: Are you giving me the floor, Mr. Chair?

The Joint Chair (Marcus Powlowski): You still have the floor.

Claude DeBellefeuille: Just because we've heard from 10,000 psychiatrists doesn't mean we shouldn't hear from the Canadian Psychiatric Association. I honestly find this completely unacceptable.

I would now like to ask Dr. van Veen a question.

I strongly believe in a person's right to decide for themselves the level of suffering that they want to endure. We know that people are treated and medicated but forced to suffer for their entire lives because psychiatry and community support won't take away their suffering. If, this evening, we were to decide to take away the ability of people with a mental illness to request medical assistance in dying, we would be engaging in discrimination. We would be excluding some people who have rights. In the absence of a clinical consensus, we would be determining that they don't have the same rights as people who have a chronic incurable disease or as people who are suffering from a disease such as Alzheimer's and who make their advance requests in Quebec. I find that somewhat unacceptable, Mr. Chair.

On that note, I appreciated Dr. van Veen's testimony. I gather that he thinks that taking away this right wouldn't be the best idea because some people with a mental illness have the right to decide for themselves and the capacity to do so. Dr. van Veen, I understand that currently some people are forced to suffer for their entire lives and to receive psychiatric palliative care at the end of their lives. It seems that, in 2026, we have a duty to give these people an option. They have the right to decide that they have suffered enough and to make the decision that concerns them.

Do you agree, Dr. van Veen, with my hypothesis that we'll never be able to take away some people's suffering?

[*English*]

Dr. Sisco van Veen: Thank you for your comments and question.

I do agree that psychiatric MAID should be available for a small group of patients. I do think there are differences between psychiatric and physical suffering, but I do not think they are fundamental enough and that there is absolutely no overlap that it would justify a total ban of psychiatric MAID.

I do think we need different due diligence criteria, but I've seen some documents from Canada that give me confidence that you are preparing for that.

● (1910)

[*Translation*]

Claude DeBellefeuille: I'll give you an example, Dr. van Veen.

In their report, the experts say that people under the age of 30 wouldn't be allowed to request medical assistance in dying. Just because you make the request doesn't mean that you're eligible. In Quebec, for example, medical assistance in dying isn't available to anyone diagnosed with an intellectual disability. Limits and criteria are used. I sincerely believe that we'll never get all psychiatrists to agree. However, we're talking here about preserving the right to self-determination.

Do you agree that members of the scientific community could settle on fairly tight criteria in order to support a schizophrenic person, for example, who, after 25 years of suffering and treatment, ultimately wants to avoid dying in what they consider completely unacceptable conditions, and that this person has the right to decide for themselves?

Can we find criteria that would help these types of people get what they want?

[*English*]

Dr. Sisco van Veen: Yes, I think so. I think the criteria in the Canadian and the Dutch law can apply to the kind of patient you described.

I do think there's consensus. There are studies being performed that show a relatively high acceptance of psychiatric MAID in the Netherlands and also abroad. I also think that, because of the polarized debate in the Netherlands, we have a silent majority which, in essence, is supportive of a restrictive option of psychiatric MAID.

I agree with most of your statements. I would argue that mercy is more important than the right to self-determination in the current Dutch system. Self-determination autonomy is necessary, but insufficient as a criterion. It's especially important in psychiatry, for psychiatric suffering, to also maintain the criteria of irremediability and unbearableness.

[*Translation*]

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

Senator Dalphond, you have the floor for three minutes.

[*English*]

Hon. Pierre Dalphond (Senator, Quebec (De Lorimier), PSG):

Thank you, Mr. Chair.

Thank you to the members of the panel.

Dr. van Veen, you were appointed, I think in 2024, chair of a committee of the Dutch Psychiatric Association to revise the guidelines applicable to mental illness. Where are you in your review of the guidelines?

Dr. Sisco van Veen: Currently, we have shifted from a total renewal of the guidelines to a more gradual renewal of guidelines, a modular renewal. We recently finished renewing the modules addressing second opinions. There are two second opinions in the Dutch due diligence procedure. We recently renewed them. We will publish them shortly.

We've just started the next cycle, which we will publish in the spring of 2027, addressing special patient groups, for instance, young patients or patients with autism and some other groups.

Hon. Pierre Dalphond: I understand that your work is not to propose to deny access but to make stricter guidelines applicable to psychiatrists before they can agree to provide MAID to people suffering from mental illness.

Dr. Sisco van Veen: Because we haven't published the guidelines yet, I can't comment too much on the substance. I'm sorry. I can say, however, that I don't think we're going to make it more strict or more lenient. It's just that we're making different access in the due diligence procedures, at different points in time, where the goal is always to find balance between safety and accessibility.

● (1915)

Hon. Pierre Dalphond: Is there an age at which it will be excluded for youth, such as 25 or 30?

Dr. Sisco van Veen: This is currently under discussion. We are currently examining that module. I cannot tell the outcome of that discussion.

Hon. Pierre Dalphond: Thank you.

The Joint Chair (Marcus Powlowski): We'll go to Senator Martin for three minutes.

Hon. Yonah Martin (Senator, British Columbia, C): Thank you very much, Chair.

Good evening, colleagues.

Thank you so much to the witnesses. I know it's very late for you, so we really appreciate the expertise you are sharing.

I know that Dr. van Veen commented on the importance of having MAID available to those suffering from mental illness, and it would be a small group, but in your account, Dr. van Os, Dutch psychiatric euthanasia became normalized gradually. Then it was accelerated. The numbers are more alarming now, with a small group of activist physicians helping drive that shift.

Can you explain how that happened in practice? Why should Canada take warning as to what could happen should we consider expanding MAID?

Dr. Jim van Os: Thank you very much for this question. I think what you would like to happen in a country is that if there is a shift in practice, particularly one like euthanasia, you want it to be well reasoned, well prepared and safe. What happened in the Netherlands was that the law, as it was formulated in 2002, was open to all sorts of uses that I don't think were initially seen as possibilities.

What you will see with euthanasia is that individual clinicians often differ wildly in what they think they see before them in terms of suffering, irremediability, futility, autonomy, etc. This is what we've seen in the Netherlands. If there is a media campaign that will sway a group of physicians who really think they are following their instincts of mercy and then expand their practice, society is not able to keep up with that and to control, deliberate and assess what is happening.

With such a difficult issue, where there's no consensus on the criteria, it's not about being against euthanasia; it's about who can address the fluctuating opinion surrounding these criteria. For example, you should have a transparent public body for oversight with representatives of disability, palliative care, psychiatry—and, in your case, indigenous and lived experience communities—and not just the activist providers. It was proposed in the Netherlands as well to have a committee of wise, experienced individuals from all corners of society to do more oversight and lead the debate.

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

Dr. Jim van Os: This is what we haven't done.

Yes, thank you very much.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Moodie, you have three minutes.

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

Dr. van Veen, your current research focuses on the intersection between psychiatry and death. You study suicide prevention, assisted death for psychiatric suffering, advanced care planning by patients with a psychiatric disorder and psychiatric complaints in terminally ill patients.

Based on your research that has studied suicide prevention, medically assisted death and psychiatric suffering, in your opinion as an expert in this area, what is the relationship between suicide prevention and medically assisted death for people with mental health illnesses?

Dr. Sisco van Veen: The short answer is that it's very, very complex the relationship between suicidality and psychiatric MAID. Even the language is complex. We've seen suicide, almost by definition, as something pathological but, if you talk to patients, especially ones with persistent suicidality, what they are mostly saying is that they miss a good conversation about their death wish, about wanting to die. They don't want psychiatrists or other physicians to act on it immediately through coercive protection in the form of MAID. They want to have a connection to talk about their death wish and not have it waved away immediately.

I think it is irresponsible to call MAID a form of suicide prevention, but there have been cases where people have requested MAID and got denied or where there is a delay in the system, and people end up dying through suicide, but I do not think we will see that in the numbers. Framing MAID—

● (1920)

Hon. Rosemary Moodie: Can I ask another question?

Is it impossible to distinguish between a rational request for MAID and the suicidality that may be present in someone with a mental disorder?

Dr. Sisco van Veen: I do not think it's impossible. I think it's complicated, but I think we have clear clinical guidelines. Competence is a construct, and we have good internationally agreed-upon rules on how to establish competence. I don't see any reason why that should not be possible for patients requesting MAID. In clinical practice, this is sometimes challenging but often something that we can do.

Hon. Rosemary Moodie: Thank you.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Osler, you have three minutes.

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

Thank you to all the witnesses who are here today.

My question touches on the question Senator Moodie just asked. My question is for Dr. van Veen.

This committee has heard from psychiatrists who have said that it's impossible in clinical practice to distinguish between a rational request for MAID and the suicidality that may be present in someone with a mental disorder. You answered it a bit in your response to Senator Moodie, but I'd be interested to hear more about how that differentiation is handled in the Netherlands.

Dr. Sisco van Veen: In clinical practice, every psychiatrist is trained to assess suicidality. That's also a continuously changing field. We are now recognizing the fact that we are really bad at predicting suicidality, but it's even more fundamental than that. I think that what we call suicidality matters, and there's not an agreed-upon definition of suicidality internationally.

It appears to me that, in the Canadian context, suicidality is synonymous with an irrational death wish. If that is the case, if that's the way we define suicidality, then it's possible to distinguish a rational death wish or a competent death wish from an incompetent death wish that is the result of psychiatric order. We have guidelines to do that, and physicians all over the world are able to do that.

Hon. Flordeliz (Gigi) Osler: That was my question. Can you tell us a bit more about the guidelines? How are the psychiatrists in the Netherlands differentiating...?

Dr. Sisco van Veen: You have the Appelbaum and Grisso criteria, which are well known and internationally recognized, to guide the competence assessment. They are really cognitive, so a patient has to be able to make a decision, explain their decision and use all of the needed information and apply it to themselves.

There are supplements in the Netherlands in our MAID guidelines with an assessment of the emotional congruence of the decision. Especially in the context of eating disorders, we are asked to see if there aren't any pathological values involved in the decision to choose death. In short, that's how we do that. There are pretty extensive, comprehensive guidelines for how to do that.

The Joint Chair (Marcus Powlowski): Thank you.

We'll go to Senator Wells for three minutes.

● (1925)

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

I have a quick question for Dr. van Veen.

Have you had a chance to look at the Canadian psychiatric guidelines that were developed? If so, do you have a comment on those, as an expert?

Dr. Sisco van Veen: Yes, but there are a lot of guidelines. I've reviewed the 20-page guidelines that were published last year, based on the Delphi study. I think they're pretty comprehensive and pretty close to our Dutch guidelines. There are small differences, but I think they're pretty thorough.

Hon. Kristopher Wells: Thank you. I appreciate that.

This question is for Dr. van Os.

In your commentary copublished in the Psychiatric Times, titled “Psychiatric Euthanasia in the Netherlands: Young People, Procedural Medicine, and the Limits of Psychiatry”, you wrote about an increasing number of youth in the Netherlands who are seeking medical assistance in dying. However, you also say in the article that “rejection and withdrawal rates remain substantial”.

You got that from the American National Library of Medicine's data that studied the requests for medical assistance in dying by young Dutch people with psychiatric disorders. That same report concluded that although there was an increase in young persons seeking MAID MI-SUMC, “Only 3.0% of all applications by young people resulted in MAID, which is lower compared with the acceptance rate for MAID-PS among adults in the Netherlands. One in 4 applications was halted by the patient even before medical files had been assembled.” Of the files that continued to be accessed, 60% were rejected due to eligibility screening. That was in your article.

Wouldn't this data which you've cited in this commentary suggest that the system developed in the Netherlands to protect against unlawful cases of MAID for mental illness as the sole underlying condition is actually working?

Dr. Jim van Os: No. Actually, I would not agree with that, because while, of course, 3% sounds like a small number, it's a relative number. In fact, there's been a growth of about 500% over five years in the number of young people getting MAID. That may still be 3% in a pool that is ever-increasing.

What happens in the Netherlands.... To clarify, we have 90,000 people, mostly young girls, presenting at the first aid departments of hospitals with non-lethal suicide attempts, and it is this pool that is more and more drawn to formulating their suffering in terms of a euthanasia request. Euthanasia requests are actually increasing to the GP, in the psychiatric practice and with the school counsellor, so we've seem an enormous increase in requests.

The 3% may be 3%, but there's a background of an increasing number of requests.

Hon. Kristopher Wells: We're running out of time. Perhaps you could send those numbers, if you have the peer-reviewed information making those comparisons. They don't add up with the numbers that we see.

The Joint Chair (Marcus Powlowski): You're welcome to submit that.

Thank you.

Dr. Jim van Os: This is of course a big topic, but not every time a GP gets a euthanasia request it is recorded somewhere in the Netherlands.

The Joint Chair (Marcus Powlowski): We're at the end of our time.

Thank you.

Mr. Lawton, you have three minutes.

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

I'd like to go to you as well, please, Dr. van Os.

In your opening statement, you were talking about this idea of euthanasia as a last resort and the lack of any prescription in Canadian law to mandate that. Earlier, we heard testimony from an advocate of the expansion, Dr. Mona Gupta, who basically said something very similar to what you were mentioning that it would not be appropriate to expect a patient to have tried every treatment available or to force them to try every treatment before going down this road.

Just so I understand the situation in the Netherlands correctly, is that the expectation there?

Dr. Jim van Os: Actually, this is a complicated question, but I'm glad you're asking it. The issue is that there are many treatments that can bring change in mental suffering. These can be social interventions. These can be existential interventions offered by a recovery academy, which is led by peer support workers. It can be a medical intervention, and it can be a complementary intervention, for example.

The thing is that in fact what we see, what is offered to patients, is mostly [*Technical difficulty—Editor*], like ECT and medication. They're not given options to the social interventions that [*Technical difficulty—Editor*]

● (1930)

Andrew Lawton: I'm sorry. There was a technical glitch there, but I'm limited in my time. I'll move on to another thing, please, Doctor.

We heard on April 21 from Daphne Gilbert. She said that if Canada proceeds with the expansion, “Clinicians agree that only a small number of people will ever meet the stringent eligibility criteria and rigorous safeguards...”. We also heard from another witness, Claire Gamache, who said, “It's a very small number.”

Based on your understanding of it, is there any reasonable conclusion that you could draw similar to what they have drawn from how Canada's laws are structured on this?

Dr. Jim van Os: Yes, but the dynamics are a bit different.

First, I think the problem is not so much how many people meet the criteria. It's that we can't agree on the criteria. Nobody can. That's the first problem.

The second problem is that once you have a procedure in place that people can apply for, desperate people will come and ask for it, and there will be unbearable suffering because it is so difficult to get the procedure. That's what we see in the Netherlands. A lot of the unbearable suffering in euthanasia procedures is caused by the fact that people think it is an option and then they become embedded and tunnelled in that particular wish.

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

Mr. Maloney, you have three minutes.

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

I want to thank all of the witnesses, particularly given the time.

We've heard from a great number of witnesses with a diversity of opinions, and your voice is very much appreciated.

Dr. van Veen, I want to start with you.

Sir, you started by saying at some point that “autonomy is...fundamental”. I agree with that. You then went on to say that “mercy” is necessary. I think I got that right: Mercy is paramount.

Dr. Sisco van Veen: I think I was the other way around.

James Maloney: Yes. I agree with both.

Then you went on to say that a doctor and a patient can decide collectively that you've “suffered enough” in a mental health situation and access MAID. Did I get that part right?

Dr. Sisco van Veen: Yes.

James Maloney: Is that statement made disregarding irremediability?

Dr. Sisco van Veen: No. In detail in the Dutch law, in shorthand we call it “irremediability”, but the Dutch law requires of us that the doctor has to establish irremediability, and the doctor and patient, in the process of shared decision-making, have to establish that there are no reasonable other options. Shared decision-making is part of our law.

James Maloney: Okay. Would you agree with me that reaching that consensus or reaching that conclusion of irremediability is based on subjective complaints made by the patient and the subjective analysis carried out by the doctor?

Dr. Sisco van Veen: All complaints are subjective from the patient's side, and I think the doctor—

James Maloney: Thank you, Doctor. I'm limited in time.

That's the difference between mental health cases and terminal cancer, as Dr. van Os referred to. In the situation you're describing where you're doing this on a subjective basis, isn't that really what Dr. van Os was getting at when he said MAID for mental health is suicide assisted by a doctor?

Dr. Sisco van Veen: I cannot comment on Dr. van Os's statements.

On the side of the doctor, it's not subjective. It's intersubjective. There are multiple doctors involved.

James Maloney: Doctor, it has to be subjective because there are no physical tests that I'm aware of that can determine that you have a permanent mental illness. You can't have a CAT scan. You can't have any other type of test that'll show that—

Dr. Sisco van Veen: There's also not a test—

● (1935)

James Maloney: [*Inaudible—Editor*] to some extent.

The Joint Chair (Marcus Powlowski): Dr. van Veen, could you briefly answer the question.

Dr. Sisco van Veen: There's not a CAT scan that can show the suffering from cancer, for instance, so suffering is always subjective.

James Maloney: No, the CAT scan shows you have cancer. A CAT scan will not show you have a mental illness. That's my point.

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.

We'll continue our conversation, Dr. van Veen. I share your opinion that a person who comes to you, who has suffered for much of their life and who can't stop their suffering, can decide for themselves what they want to do in consultation with their doctor.

The latest report by Canadian experts that we saw shows that, given the fairly tight criteria, it's almost impossible for a 30-year-old to qualify for medical assistance in dying. We must prove that the person has taken medication, received follow-up care and undergone therapies, and that, after a few years of unsuccessful treatment, the suffering persists. That's what it takes for a person to have the right to decide for themselves.

I would now like to address an issue raised by my colleague concerning cases involving irreversible suffering. If you have schizophrenia and you have been in therapy for 20 years or so without seeing any results, and you're suffering, it seems that you have the right, as a patient and as an individual, in consultation with the doctor evaluating you and with all the professionals, to decide whether you want to continue to live with your quality of life.

I often hear a form of paternalism from some of my colleagues around the table. They're not able to trust a person's ability to make a decision. Would it be better to say that we can allow these people to make this decision, but take a case-by-case approach, since some may have the right to do so? If we fail to listen, we'll be discriminating against a minority of people who could have the right to put an end to their years of suffering.

[*English*]

The Joint Chair (Marcus Powlowski): That's quite a lengthy question with not a lot of time to respond, in fact, no time. I will give a brief opportunity for a response.

[*Translation*]

Mrs. DeBellefeuille, whom are you asking?

Claude DeBellefeuille: Dr. van Veen.

The Joint Chair (Marcus Powlowski): Okay.

[*English*]

Dr. van Veen, could you give a brief response.

Dr. Sisco van Veen: Yes, it was quite a long statement.

I largely agree. We're focusing a lot on young women, but if we look at the numbers, the most common people are people of middle age with depression. Maybe that's a good statement to make.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Dalphond, you have two minutes.

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

Dr van Os, you said there was an increase of 60% over the last year. You're referring to what you wrote in an article a few weeks ago. It was from 138 in 2023 to 219 in 2024. That's the number of 60%.

Dr. Jim van Os: Yes, that's the under thirties.

Hon. Pierre Dalphond: Yes, thank you.

When you refer to the 500% increase, you go many years back to 2002, when there were about two or three people receiving it every year.

Dr. Jim van Os: That's the rise from five to 30, over 2020 to 2024.

Hon. Pierre Dalphond: Okay.

Dr. Jim van Os: That's also the under thirties.

Hon. Pierre Dalphond: You also refer to suicide. I understand that, in 2023, the last number we have is 138 cases of euthanasia for psychiatric grounds and 1,900 suicides. It still represents a small portion, less than 7% of those who are dying because, I understand, in your country suicide and euthanasia are part of the same subclass for statistical purposes.

Dr. Jim van Os: In medicine, we consider premature death as a class because they are related, very strongly correlated. Euthanasia is one form of premature death. Accidents and suicides are in the same class, and they are correlated. We see, in the under thirties, that euthanasia as a form of premature death is taking an increasingly large proportion of all premature deaths in youth under 30 years.

● (1940)

Hon. Pierre Dalphond: It's less than 10%.

Dr. Jim van Os: It's less than 10%, but it's a lot for euthanasia to have that kind of proportion.

Hon. Pierre Dalphond: The number of suicides is not increasing or decreasing. It's stable.

Dr. Jim van Os: It's increasing a little bit in young people in the Netherlands.

The Joint Chair (Marcus Powlowski): Thank you.

The last two minutes are for Senator Martin.

Hon. Yonah Martin: Thank you.

Earlier, Dr. van Veen was asked whether it's possible to distinguish suicidality from a rational request for MAID.

Dr. van Rooij, it is also then possible for a psychiatrist to erroneously conclude that it's a rational request for MAID, is it not?

Dr. Wilbert van Rooij: It's definitely possible. From a lot of evidence coming up in the Netherlands in public debate, a lot of pro-euthanasia and pro-MAID activists have shared a lot of information about patients who received euthanasia. Concluding from that, a lot of debate arose among Dutch psychiatrists as to whether the due diligence criteria were observed. In some cases, there is serious doubt among psychiatrists. There's no consensus at all.

Hon. Yonah Martin: If there's an error, there's no recourse. The person is already dead.

Dr. van Os, suicide contagion is a concern, which we've heard from witnesses, particularly in the indigenous communities in Canada. Is this a concern being discussed in the Netherlands?

Dr. Jim van Os: Yes, it is discussed, but belatedly. We are now imploring the media to not report on euthanasia in a romanticized fashion like they used to with pictures and using terms like, “It was very courageous” and “It's beautiful” and “We let them go in love” because we know those have a very strong contagious effect on young women who feel trapped or emotionally unstable to adopt a similar death wish in the form of euthanasia requests.

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

With that, we conclude this panel.

I would very much like to thank all of you from Holland for participating. We realize that you've had to stay up late into the night, but we do appreciate hearing your evidence and your experience from Holland.

I'll take my prerogative as chair to also mention that I very much like your soccer team, given their history and their style of play. I wish you good luck in that, too.

Thank you. Good night.

● (1940)

____________________(Pause)____________________

● (1945)

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

I'd like to welcome our second group of witnesses.

As an individual, we have Alicia Duncan, by video conference.

From Dying With Dignity Canada Inc., we have with us Helen Long.

From Euthanasia Prevention Coalition, we have executive director Alexander Schadenberg.

Maybe we can start with Ms. Duncan.

You have the floor for five minutes. I will hold up a prompt when you have 30 seconds left and another when your time is up.

Go ahead.

Alicia Duncan (As an Individual): Hello. My name is Alicia Duncan, and I am here today in memory of my mother, Donna Duncan.

I first appeared before this committee in 2022. As someone who is not philosophically opposed to assisted dying, I believed that if Parliament understood what happened to my mother, there would be change. There hasn't been. AMAD has recognized that this issue turns on readiness, oversight, standards and review. The circumstances surrounding my mother's death demonstrate that Canada is not ready to expand MAID for mental illness as a sole underlying condition.

My mother's death demonstrated these three things: One, families cannot reliably intervene to stop a MAID death in real time, even in a clear crisis. Two, after death, there is no effective pathway to determine whether the law was followed. Three, oversight in this system, therefore, is not verifiable in practice.

My mother died through Canada's MAID regime on October 29, 2021, only hours after being released from a psychiatric unit following a suicide attempt. She had experienced a significant decline following a concussion. She was psychiatrically unstable, deeply hopeless and physically deteriorating. Our family did not deny that she was suffering. We questioned whether death should have been accepted as the answer in the midst of that crisis.

When she told us she had scheduled her death in less than two days, we brought an emergency application before a provincial judge, who granted a warrant for her apprehension under the Mental Health Act temporarily stopping the provision. With her consent, we then spoke directly with the head of the MAID coordination centre, who was also one of her assessors, and raised concerns that she was in an active mental health crisis. That concern was confirmed when she attempted suicide, yet hours after being released from psychiatric care, she was euthanized.

Proponents of psychiatric euthanasia frame my mother's case as an outlier. It is not. Since her death, I have connected with many families across this country who have experienced similar circumstances and are now living with the devastating effects of PTSD, conditions that, under an expanded regime, could themselves become grounds for MAID.

In my mother's case, disordered eating and severe caloric restriction contributed to her physical decline and were treated as evidence that her death was near. In effect, the current system allows eligibility for MAID to be shaped not only by illness, but also by behaviour rooted in distress, including self-imposed physical conditions.

After my mother's death, the second failure became clear. We pursued regulators, police and the Privacy Commissioner to determine whether the law had been followed. A police investigation was opened but could not proceed because officers could not access her MAID assessment records. Requests for disclosure, including under public interest provisions, were refused. Most recently, I requested her records under public interest override of B.C.'s Freedom of Information and Protection of Privacy Act. That request was again denied.

I would ask this: What greater public interest exists than determining whether a state-authorized death was carried out in compliance with the law? The only person legally entitled to access the records that would answer that question is my mother, and she is dead.

There is no governing body in this country, criminal, civil or regulatory, that seems willing to reliably determine whether a MAID death complied with the law after it has occurred. Accountability is effectively shifted onto families and executors, who cannot access the information required to pursue it. Public bodies defer to one another. Health authorities resist disclosure, and civil action carries significant financial risk for families. The absence of a negligent finding is often cited as evidence that the system is working. It is not. It reflects a system that cannot be meaningfully examined.

It is within that system that Parliament is now being asked to expand eligibility. When I hear that Canada is ready for expansion, I do not understand how that conclusion is reached. My mother's case has been examined in courts, media and public policy discussions. If a case like hers does not raise fundamental concerns about how the system operates, it is unclear what would.

Nothing fundamental has changed since 2022. Canadians still lack timely access to psychiatric care, trauma care and meaningful recovery supports. We are preparing to authorize psychiatric euthanasia within a system that lacks transparency, meaningful oversight and any reliable way to verify whether the law is being followed.

When MAID is provided in error, the consequence is irreversible. If Canada cannot account for the deaths it has already approved, it is not ready to expand eligibility to mental illness as a sole condition. We are not ready.

Thank you.

● (1950)

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

Ms. Long, go ahead for five minutes.

Helen Long (Chief Executive Officer, Dying with Dignity Canada): Good evening, everyone. Thank you for the opportunity to appear.

My name is Helen Long, and I am the CEO of Dying with Dignity Canada. We are a national human rights charity that advocates for end-of-life options that respect the Canadian Constitution and the Charter of Rights and Freedoms.

We support the right of a competent adult with a mental illness as their sole underlying medical condition to apply for and receive medical assistance in dying if they meet the rigorous eligibility criteria under the Criminal Code.

The legalization of MAID for mental illness would allow access to MAID for a small group of people afflicted with acute treatment-resistant mental disorders who, despite many interventions over long periods of time, have experienced suffering that cannot be relieved.

This committee has heard from many physicians, psychiatrists, professors and other experts who have contributed invaluable testimony to the committee's study. Some experts have stated that mental illness cannot be considered grievous and irremediable. Their illness and outlook may possibly improve one day in the future, but certainty about the future is not a requirement to access MAID. There is plenty of uncertainty in many medical conditions, but people with physical disorders are informed about the uncertainties and engage in dialogue with clinicians to talk about risks and their own values. It is to only people with mental illness that we say, “Your views do not matter.”

I remind you that 80% of Canadians support access to MAID for individuals with a mental illness as the sole underlying condition. There are physicians who are confident in their ability to assess and provide MAID for mental illness. Their ability and willingness to do so is based in fact, backed by robust academic literature and affirmed by countless hours of experience in clinical settings. They are prepared to honour the wishes of the very few Canadians who would be eligible to receive MAID for debilitating, irremediable mental disorders.

Today I would like to highlight a glaring gap in the evidence collected by the committee. The voices of everyday Canadians with lived experience facing grievous and irremediable medical disorders have been largely excluded from your study. No other patients have been erased from a conversation about them the way persons with mental illness have been. I am here as an advocate for them, to bring their voices to you with the limited time I have. However, my testimony should be the start, not the end, of a conversation with Canadians who have been consistently calling for the legalization of MAID for mental illness.

John Scully has said:

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

Here is Savannah Meadows:

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

Clemie said:

> I do understand the concept that there’s always hope, that my life could get better, but my anguish won’t. I will always be mentally ill. I will always be depressed. My heart can’t handle this pain anymore, my soul is exhausted, and I deserve equal access to assisted dying.

Claire Elyse Brosseau said this:

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

At its core, the decision to access MAID is a deeply personal one. Canadians simply want the autonomy to make medical decisions for themselves in consultation with the medical professionals they trust. It is incumbent upon the government of Canada to allow them to do so.

I urge this committee and the government to go further in listening to their voices, and ensure their realities are meaningfully reflected in the recommendations you put forward.

Thank you.

● (1955)

The Joint Chair (Marcus Powlowski): Thank you.

Mr. Schadenberg, go ahead for five minutes.

Alexander Schadenberg (Executive Director, Euthanasia Prevention Coalition): My name is Alex Schadenberg. I'm the executive director of the Euthanasia Prevention Coalition. I work in Canada, but I also work with people worldwide who oppose euthanasia and assisted suicide.

Canada is increasingly seen internationally as a cautionary example. The rapid growth of euthanasia deaths and the expansion of the types of cases are being closely watched abroad. Developments in Canada have influenced debates in other countries, including the defeat of assisted dying bills in Scotland, the U.K. House of Lords, and Slovenia, where assisted suicide was overturned through a referendum.

Rather than extending assisted dying to persons whose sole underlying condition is a mental disorder, Parliament needs to examine how Canada's euthanasia law is actually functioning. How has the law been implemented? Is it achieving its intended outcomes? Are there abuses of the law based on its original intention? Does the law require amendments? These questions have never been addressed. We've only actually talked about expansions.

Dr. Ramona Coelho, in her article, dated January 5, 2026, published by the Macdonald-Laurier Institute, as a commentary on the "Sixth Annual Report on Medical Assistance in Dying", stated:

> Although the report emphasizes self-identified disability, all MAiD recipients are disabled by definition. Disability refers to any long-term impairment that limits participation in life. MAiD is legal for individuals with a "grievous and irremediable" condition, an incurable illness causing irreversible decline in capabilities. Anyone meeting these criteria is by definition disabled, though not all disabled people should qualify for MAiD.
>
> Common conditions listed for Track 2 MAiD reinforce this point. Diabetes appears frequently, and Ontario's MDRC documented a man who received MAiD for an essential tremor. These are disabilities, yet they do not usually cause the serious decline that MAiD is intended to address. By emphasizing self-identified disability, the report obscures the real story: MAiD eligibility targets disabled people, a concern highlighted by the disability community, the United Nations and human rights watchdogs, and most recently, the United Nations Committee on the Rights of Persons with Disabilities.

That UN committee has called for the repeal of track 2 MAID, increased oversight of the law and no further expansion, including the scheduled expansion of MAID for the sole criteria of mental illness.

For instance, Kiano Vafaeian, who was 26, died by euthanasia in Vancouver on December 30, 2025. Kiano was seeking assisted dying in Ontario where he lived, but his requests for MAID were rejected by multiple doctors in Ontario. He then contacted Dr. Ellen Wiebe in Vancouver, British Columbia, who assessed him and approved him for euthanasia.

Margaret Marsilla, Kiano's mother, was shocked that her son, who was living with type 1 diabetes, which did result in his becoming legally blind, was also living with significant mental health issues, which should have been assessed in his approval for MAID. Kiano was approved as a track 2 candidate for MAID. Kiano's family was never consulted, which is important, since he was living with depression and suicidal ideation.

If Kiano's death is the only disturbing MAID death, then one might suggest his death is an outlier. However, in fact, there have been many controversial MAID deaths.

Instead of expanding MAID further, Parliament needs to examine how the current law has led to outcomes such as the death of Kiano. Parliament needs to have a complete review of the law.

More broadly, Canada's assisted dying law is vague. While Health Canada provides guidance, the legal framework allows for wide interpretation, and it lacks effective oversight.

Because of the time constraints, I'll only highlight one key issue. Section 241.2(3) and section 241.2(3.1) of the Criminal Code state that medical practitioners or nurse practitioners are only required to be "of the opinion" that the eligibility criteria are met. Now, we're talking about life and death decisions here. That, in practice, makes accountability extremely difficult, and it makes it impossible to prosecute a medical or nurse practitioner in Canada, even when the MAID death is clearly wrong or deeply disturbing.

The MDRC reports from Ontario and cases that have already been submitted to you speak to that reality.

Canada should not be considering the expansion of MAID or of assisted dying to include people with mental illnesses alone, but rather, Parliament needs to fully review the law.

Thank you.

● (2000)

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

We go now to our first round of questioning with Ms. Jansen for five minutes.

Tamara Jansen: My questions are for Alicia Duncan.

Previously at this committee, Jocelyn Downie said in her testimony that nobody who applied for MAID didn't want it. What do you think of that statement? Did your mom really want MAID?

Alicia Duncan: My mom told me in the week before her death that she did not want to die, but she just couldn't live like that anymore. She felt she had not received appropriate care.

Tamara Jansen: You also tried to tell MAID assessors your concerns about your mom, her not eating due to mental illness, and that she wasn't actually dying, just malnourished. What did the MAID assessor tell you in response?

Alicia Duncan: I actually have a text message from the MAID assessor, Dr. Grace Park, who said to us that her health had declined with significant weight loss, which put her on a trajectory to foreseeable death. Some blood tests show signs of malnourishment, but they have to be requested specifically. She ended by saying, "If Donna wishes to proceed, there's not much any of us can do to prevent her from accessing her legal option to do so."

Tamara Jansen: What did the blood work from the MAID assessor show?

Alicia Duncan: She said that specific blood work would need to be requested. Blood work was actually done in the hospital, and it said—and I'm reading from her medical records right now—"Donna has had a full panel of blood work recently, including a CBC, lytes, liver and renal function, thyroid function, B12 level and a toxicology screen. All her results were normal."

Tamara Jansen: In your previous testimony in 2022, you also spoke to the fact that your mom's GP refused to assess her, because he didn't believe she'd follow through with his recommendations for treatment, but felt obligated to refer her. Was your mom's diagnosis ever diagnosed by someone with expertise?

● (2005)

Alicia Duncan: No. My mother's vital statistics death certificate listed MAID, and then the underlying conditions were frailty, cachexia and central sensitivity syndrome. My mother was actually waiting for an appointment with a chronic disease specialist, and that appointment was for two weeks after her death. She never made it to the specialist.

Tamara Jansen: Your mother was euthanized only hours after being released from a psychiatric unit following a suicide attempt. If Canada cannot safely navigate a case like that under the current regime, how can Parliament seriously claim it's ready to expand MAID to mental illness alone?

Alicia Duncan: It's completely irresponsible to be expanding this. In a case like this, my mom should have been stopped at many different periods throughout the legal and medical system, and there was nothing that anyone could do to stop it.

Tamara Jansen: I understand that despite obtaining a Mental Health Act warrant and raising direct concerns with the MAID coordination centre, your family still could not stop your mother's death. What does that say about the ability of families to raise urgent mental health concerns if this regime is expanded to solely underlying mental illness?

Alicia Duncan: It goes back to the questioning in our first panel, actually. We are so focused on autonomy that we forget that there's also mercy in this as well. My mom was deemed capable to make this decision for herself, but she was clearly in a mental health crisis. If you can't determine the two of those, then there is absolutely no way we should be expanding this.

Tamara Jansen: In your mother's case, disordered eating and severe caloric restriction were effectively treated as evidence that death was near. Does that show that behaviour rooted in mental distress can be converted into MAID eligibility, and why should that alarm this committee before 2027?

Alicia Duncan: Most concerning, any young person with an eating disorder, or in my mom's case, a 61-year-old who had a lifelong pattern of disordered eating, can restrict their calories so they become frail. For anyone who is frail, under our current regime, their death can be found to be reasonably foreseeable, and they can die now within 24 hours.

Tamara Jansen: One of the most striking parts of your testimony is that after a MAID death, there's still no reliable way to verify whether the law was followed, because families, police and regulators cannot access the necessary records. If Canada cannot account for the deaths it has already approved, why should it expand eligibility to mental illness as a sole condition?

Alicia Duncan: I wish I knew the answer. I have no idea why people think this is a reasonable expectation when we cannot verify deaths are legal currently.

Tamara Jansen: Since your mother's death, many families have contacted you with similar experiences, I understand, showing that her case was not an outlier. What's your assessment of the risk of more of these cases occurring in Canada if we allow MAID for mental illness?

Alicia Duncan: There are many points that have been brought up by experts. For me, my biggest concern is that we aren't considering the third party impact for families. I know many people who have been diagnosed with PTSD. My sister and I were diagnosed with PTSD, which, ironically, would qualify us for MAID if this should expand. The studies just haven't been done properly for us to actually understand the full effects of what is going to happen should this expand.

The Joint Chair (Marcus Powlowski): Thank you.

Mr. Schiefke, you have five minutes.

[*Translation*]

Peter Schiefke (Vaudreuil, Lib.): Thank you, Mr. Chair.

First, I would like to say that I'm happy to be here with my colleagues from the Senate and the House of Commons for this crucial study.

[*English*]

Chair, I'm going to start my questions with Ms. Long.

Ms. Long, first, I want thank you for your work and your advocacy. I was a supporter of medical assistance in dying when our government was faced with the challenge of moving this forward back in 2016. I think that we found the necessary balance in order to provide Canadians with the right to do so.

In this particular instance, though, based on the research that I've done and looking at the testimony received so far including in the last panel as well, we heard Dr. van Os say that the UN Committee on the Rights of Persons with Disabilities, the International Association for Suicide Prevention and lived experiences in Holland say not to move forward with an expansion of MAID in Canada. We heard Dr. van Rooij say that euthanasia requires certainty and we simply do not have certainty when it comes to mental illness. We have had psychiatric associations and many other practitioners who have appeared before committee over the last 15 hours or so of testimony who have said that there is no consensus and that we should not move forward. As recently as just a couple of days ago, the Province of Quebec, where I call home—I represent the community of Vaudreuil in that province—shared a letter with us reiterating the fact that the province has not moved forward or given their support for an expansion. They had conducted their own study, which came to the consensus that they should not move forward. It did not have the public support necessary to do so as well.

Whatever I say here doesn't count. It's your testimony that will make its way into our report and will determine whether we recommend to move forward or not. What are we missing? What are all of these experts, provincial governments, etc., missing? What would be your strongest arguments against what they have said?

● (2010)

Helen Long: You've heard from many experts. I would point to testimony from professors Downie and Gilbert around the constitutional challenges. I would point to testimony from psychiatrists like Mona Gupta and the Canadian Psychiatric Association, which has provided guidelines in Quebec and across Canada to move this forward.

I would think about consensus. Before MAID became legal, palliative care physicians argued that palliative care could alleviate all suffering. We now know that isn't the case, and I can point to papers that support that. Others disagreed, but the Supreme Court didn't let that lack of consensus stop the first assisted dying laws.

Consensus is not a requirement. This government is formed and acts without consensus all the time. I think there is a lot of evidence on the table. Canadians support assisted dying. We see numbers for the Carter decision in the 85% range and for medical assistance in dying specific to mental illness in the 80% range. That's across all demographics. Track 2 is supported by Canadians, including those living with a disability. I think there's a breadth of evidence.

Peter Schiefke: Thank you very much, Ms. Long.

The next question I have is for you, Mr. Schadenberg. Thank you for being here, sir.

I co-chair the all-party cancer caucus with my Conservative colleague, Dan Albas. We've both had our own personal experiences with cancer. I fully support those who are going through significant pain and have been given a diagnosis that they're near end of life. Being able to end that at the time of their choosing is something I wholeheartedly support.

What would be the argument you would give to somebody who asks that? By denying those whose sole illness is mental illness the right to access medical assistance in dying, wouldn't that be denying them their autonomy and their freedom to make the choices that they deem necessary for themselves? This is something that my colleague Madam DeBellefeuille pointed out. What would your argument be to those people who made that statement?

Alexander Schadenberg: I don't consider them to be identical statements, because you were talking about cancer pain, and that's a completely different thing from psychological pain. We're hearing psychiatrists say to us very clearly that to assess a grievous and irremediable medical condition for psychiatric conditions would assume that there is a clear consensus or a clear way to say that this person is not going to get better, and they say that's not possible.

We're talking about a diagnosis that is not able to be confirmed, yet the question is, can we go ahead with MAID euthanasia in those cases? If it were a physical condition, and we said that case is clearly not irremediable, they are not dying and they are not irremediable, then they would say, “We can't accept you for MAID”, yet we're saying with mental health, “Oh, well, we can't determine that, but we might go forward anyway.”

The Joint Chair (Marcus Powlowski): Thank you.

[*Translation*]

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

Claude DeBellefeuille: Thank you, Mr. Chair.

Ms. Long, we know that the Quebec minister of health wrote a letter to the committee. Mr. Schiefke spoke about it. She says that the province isn't necessarily ready to expand access to medical assistance in dying. However, she also isn't asking for the removal of the possibility, under the legislation, of requesting medical assistance in dying. I think that we need to keep doing research. Perhaps this small nuance in Quebec's position wasn't emphasized. We also know that Nova Scotia told us that it was ready.

In your remarks, which touched me deeply, you said the following. Why deny medical assistance in dying to a small number of people who are suffering from a mental illness and who could have access to it? You said “a small number”. You said that the criteria recommended by the experts are fairly restrictive.

Do you think that this will apply to a small number of people?

● (2015)

[*English*]

Helen Long: Yes. I think Dr. van Veen spoke to this. It would suggest a small number.

We always talk about MAID in the context of case-by-case assessments. Clinicians have to practise within their scope and expertise. Individuals in this situation have to consult with psychiatrists or psychologists, those who work in the mental health space. They can't provide MAID without that expertise. A full assessment requires that all those eligibility criteria and safeguards are reviewed.

There's also the risk of professional and criminal liability, which is certainly significant. I think this encourages clinicians to do the right work. Canadians are confident in the health care system. They're confident in their clinicians. I know we often speak as if they're running amok, but I think the system is a good system. We have clinicians who are qualified to do the work and have stated so.

[*Translation*]

Claude DeBellefeuille: As you know, we see a great deal of misinformation suggesting that a suicidal person could access medical assistance in dying. However, the expert report states that, if a person is suicidal, they can't access medical assistance in dying because they're in a state of crisis. They need to be in a stable condition. So, regarding the argument that we would be encouraging suicidal people to request medical assistance in dying, I would say that the opposite is actually true. Sometimes, people who have been suffering for many years and who have no other solution choose to end their lives by suicide, or by refusing treatment, continuing to take their medication or seeking help, knowing full well that this will ultimately lead to psychiatric palliative care.

Can you give us some examples of people who, under the current criteria, would be eligible for medical assistance in dying on the basis of a mental illness?

[*English*]

Helen Long: Certainly. Dr. Gupta spoke to the need for clinicians to assess suicidality and ensure that the person is not in crisis.

I'm thinking about Claire Elyse Brosseau. Many of you will have seen the media today on her recent filing. This is an individual who has 35 years of significant care. She has had access to every treatment she could have wanted. She has worked extensively with multiple psychiatrists. Her psychiatrist supports her decision. That's one individual. John Scully is another. You can see information on his story on our website. Certainly, there are very few of these people. There are, perhaps, one or two others.

We talk to clinicians, psychiatrists in particular, who do this work and who have thought about their patients over the many years. One clinician, for example, said, “In my 40 years, perhaps I've seen four people who may qualify.” There are very few when you look at the numbers. I could provide some numbers related to the calls we get. We are not clinicians. We don't assess for eligibility, but I can certainly tell you that the vast majority of those who call and identify with a mental illness tell us that they either have not been diagnosed or have not received treatment. Those people would never be considered for MAID.

[*Translation*]

The Joint Chair (Marcus Powlowski): Thank you, Mrs. DeBellefeuille and Ms. Long.

Senator Dalphond, you have the floor for three minutes.

[*English*]

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

Mrs. Duncan, thank you for telling us your story.

You told the story three years ago. If my recollection is good, your mother was a psychiatric nurse.

Alicia Duncan: Yes, she was.

Hon. Pierre Dalphond: She had a car accident and suffered a concussion. After a battery of tests, she was...suffering from central sensitivity syndrome.

Alicia Duncan: She was never diagnosed formally with central sensitivity syndrome. My mother believed that she had central sensitization syndrome, actually.

Hon. Pierre Dalphond: She was living with a partner.

Alicia Duncan: She was, yes.

Hon. Pierre Dalphond: Yes.

You went to court to get an injunction to force her to be hospitalized. You got the injunction—

Alicia Duncan: We—

Hon. Pierre Dalphond: —and she was in the hospital for two days.

Alicia Duncan: We received a warrant for her apprehension under the Mental Health Act for further assessment. When the MAID appointment was postponed, she attempted suicide. That's when she was sectioned in the psychiatric unit that she used to manage.

Hon. Pierre Dalphond: Then, after a few days, the doctor concluded that she could be released. She went back home and she received MAID at home in the presence of her partner.

Alicia Duncan: That's correct.

Hon. Pierre Dalphond: The partner said to CTV, “People don't realize the pain she was in.”

That's the full story, just to complete the story.

Thank you very much, Mrs. Duncan.

● (2020)

Alicia Duncan: Yes. We don't deny that she was suffering.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Martin, you have three minutes.

Hon. Yonah Martin: Thank you to our witnesses.

This is a question for Mr. Schadenberg.

Some defenders of the current regime argue that the colleges of physicians and surgeons can regulate bad practice. My family has personally experienced some medical errors with my father. He eventually passed away. It was next to impossible for us to follow that up with anything that we knew we could do. It was very difficult.

Based on the cases you have followed, has professional regulation proven to be a meaningful safeguard? I think we need these checks and balances. I'm asking based on the cases you've followed and some you've mentioned today.

Alexander Schadenberg: I want to make two points.

The first point deals with a comment made by the nice lady beside me, and it is that doctors can be prosecuted for this. They're very concerned about this. They have to be very careful.

In fact, when you look at the Criminal Code, it's impossible to do so. The law was written in such a way as to make it impossible, because it says that the doctor or nurse practitioner only has to "be of the opinion" that you fit the eligibility criteria of the law. That's not the only thing in the law which is concerning, but obviously, they simply have to say that they were of the opinion and that's it. It's done.

As for regulatory bodies in the provinces, there have been a few cases that have gone to regulatory bodies, but there have been no significant or any issues. The biggest issue was with a doctor in Ontario. It was a very egregious case. The Ontario college of physicians decided to say that the person cannot be involved in MAID anymore, but nothing else was done. In that case, the person continued to be a physician in every way, shape or form, but they were told they cannot be involved with MAID anymore. That's it.

Hon. Yonah Martin: In your testimony, you talked about how we haven't done a full review. I agree, because the numbers are showing increasing "choice of or uptake of" MAID. We also hear about more cases of problematic situations. What specifically do the current outcomes tell you that makes a 2027 expansion unsafe?

Alexander Schadenberg: It's impossible to expand MAID to mental illness when you consider how the current law is working and also how the language is set in the law. I say that for two reasons. One is the question when I answered the previous question about irremediability: If you cannot determine irremediability, then, obviously speaking, people would not qualify.

Let's say you have someone from their own professional experience deciding that this person was irremediable, then it would be, once again, a situation of doctor shopping, where people who wanted to die by MAID would go to that specific psychiatrist because that's the one who's willing to approve them. They only have to say, according to the law, that they're "of the opinion" the person fits the criteria of the law—

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

We go now to Senator Moodie for three minutes.

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

Ms. Long, I would like to ask you questions about indigenous consultations. In reviewing the Dying with Dignity website in preparation for these hearings, I was struck by the fact that you amplify the voices of diverse communities.

There is a conversation you have on the website with an indigenous mother, Marion Brown, and her daughter, Danielle Wilson-Brown, who have a podcast, "Before I Go...Embracing the Journey of MAiD".

You clearly are attentive to evidence about, and seek to engage, indigenous people. We have heard in this committee that the only consultation with indigenous peoples in Canada was the 250 people answering an online questionnaire. Of course, it is essential to properly consult indigenous people. I ask you this question: Are you aware of anything more that was done besides the online questionnaire?

Helen Long: Yes. Health Canada issued a report in 2025 with a number of engagements, virtual, in person and round tables across the country, as well as surveys and consultations. You can also see several stories on our website are related to people with indigenous stories related to care, assistance in dying and related topics. In the podcast from the Browns, they also talked with indigenous consultants, practitioners and families that had been involved.

There's quite a broad breadth of expertise in that space.

● (2025)

Hon. Rosemary Moodie: Thank you.

Ms. Duncan, your mother's case was reviewed by the B.C. oversight committee, the College of Physicians and Surgeons of BC and the police. There was no finding of professional misconduct or criminal conduct of any sort. There was no disciplinary action. There were no charges passed. Multiple psychiatrists were involved in her care. Multiple MAID assessors were involved in her care.

Do you agree with what I just said?

Alicia Duncan: The College of Physicians said it was a criminal matter and referred us to the police. The police investigation was then halted, because they couldn't access the MAID assessment records that the health authority denied them and repeatedly denied our family as well. There's nothing we can do to get them.

Hon. Rosemary Moodie: I think we have a problem here. If what you're saying is that a health authority refused to give the police information, then that would be a problem.

Alicia Duncan: It's a huge problem. This is what I continue to talk about. This is a very, very huge problem.

Hon. Rosemary Moodie: I don't think it's a problem of MAID assessors, and I don't think it's a problem of choosing MAID and providing MAID. I think this is a systems problem that is between the police and the health care system. That is the problem.

Alicia Duncan: Do you think we should expand this program that's irresponsible?

Hon. Rosemary Moodie: Excuse me, Ms. Duncan. I ask the questions here.

Thank you for your answer.

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

We go now to Senator Osler for three minutes.

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

Thank you to all the witnesses for being here today.

Ms. Long, you've been the CEO of Dying with Dignity for six years. In your testimony this evening, you stated that people "want the autonomy to make medical decisions". You provided three perspectives and quotes.

Would you share with the committee the perspectives you have heard, in your work with the organization, regarding autonomy?

Helen Long: Yes, certainly.

We are a human rights organization. We are focused on end-of-life choice and care, so the perspectives we hear are generally supportive of MAID. Individuals wish the ability to control their final days. They wish to be able to choose what kind of health care they receive as they near end of life. They want to make decisions for themselves. While most people want to involve family and loved ones, ultimately, individuals want to make their own decisions. They want to be informed about all the options. They want to be able to choose themselves which path to go down.

Hon. Flordeliz (Gigi) Osler: Thank you.

You provided three quotes from people. Are they outliers?

Helen Long: They're outliers in terms of the number of individuals we work with. Most of the people we talk to are people who wish to access MAID under track 1, or who are gathering information about MAID under track 1. We hear from people talking about track 2 as well, people living with disabilities or illnesses but who are not reasonably foreseeable. Then there's a smaller number in relation to mental illness.

Again, of the people we hear from, many of them are not providing information that would suggest they're eligible. There are more stories on our website, maybe 20, like the small quotes I provided. They represent most of the individuals we've heard from who have a truly compelling story and who feel that they may actually be able to access MAID through this channel at some point. Some are individuals we have lost during the years of delay, of course.

Hon. Flordeliz (Gigi) Osler: Lost to....

Helen Long: To suicide.

Hon. Flordeliz (Gigi) Osler: Thank you, Ms. Long.

Thank you, Mr. Chair.

The Joint Chair (Marcus Powlowski): Thank you.

Senator Wells, you have three minutes.

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

Ms. Long, our committee has heard testimony primarily from multiple witnesses who disagree that MAID should be allowed for persons with a mental illness, despite empirical evidence to substantiate these claims. One of the arguments that's been brought up a few times is the idea that someone who is suicidal or has suicidal ideations can easily access MAID. But we know that here in Canada, to access MAID under the law, a person must meet very strict eligibility requirements. Being suicidal is not an eligibility criterion to access MAID.

From your experience, do you believe people with suicidal ideations can easily access MAID? As well, based on your experience, have the people who have sought MAID simply given up, or have they genuinely tried to make every possible treatment first before making the decision to request MAID?

● (2030)

Helen Long: No. The stories I recounted in quotes are from individuals who have had decades of treatment. They have tried every option available. These are individuals who generally have access to good care. They're usually fairly affluent or in a good situation, so they have been able to access the care they need. They feel they have no ability to get any better than they are. Read Claire's story on our website. I provided a number of these in my original submission. She acknowledged that she has had good days from time to time, but not in recent years. She feels she will never be well enough to live a life that is fulfilling and happy.

There are a number of these stories. These are individuals who truly have made every effort and finally decided that they are not prepared to continue to go on. That is their choice. They have consulted with their psychiatrists and clinicians. They're not making the decision in a vacuum. In many cases, like Claire's, they have the support of family around them.

Hon. Kristopher Wells: Thank you.

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

We'll now go to the second round of questioning, starting with Mr. Lawton for three minutes.

Andrew Lawton: Ms. Long, in your written submission, you said, “Individuals experiencing suicidality...will not be eligible.”

Before this committee, Dr. Sonu Gaind, Dr. John Maher, Dr. Allison Crawford, Dr. Sandip Gandham, Dr. Margaret McKinnon, Dr. Jitender Sareen and Dr. Sanjeev Sockalingam all testified that physicians cannot accurately distinguish between the desire to die by MAID and suicidality.

They are physicians. You are not. What do you know that they don't?

Helen Long: I would just point to the physicians—there have been a much smaller number here—who did comment that they are able to assess suicidality, like Dr. Gupta and others.

Andrew Lawton: It doesn't concern you that many of them don't believe they have the capacity to do that, as physicians.

Helen Long: Those who are prepared to do the work believe they have the capacity. Should they be in a situation where they don't feel they can assess that, I am quite confident they would consult others with expertise, or they would deny the person eligibility approval.

Andrew Lawton: Your organization has a record of suing institutions that do not feel it is suitable to offer this.

Are you saying that you will waive this in the future when a practitioner does not feel this is an appropriate course of action to take?

Helen Long: Our institution has a record of supporting legal challenges that support charter rights.

Andrew Lawton: Okay. Therefore, you will potentially sue practitioners who don't want to provide MAID for people with mental illness.

Helen Long: No, we will not. Every clinician has the ability to decide when and if they wish to assess for or provide MAID. There will never be a lawsuit from us forcing clinicians to take any kind of action.

Our lawsuits are focused on constitutionality and charter rights.

Andrew Lawton: We have seen through a lot of the testimony we heard and a lot of the research on this an intersection between mental illness and external factors like loneliness, poverty, insecurity and lack of social network.

How many of those things do you feel should justify someone in seeking MAID?

Helen Long: Those are not factors that are part of the eligibility criteria.

There are several papers. Dr. James Downar, Jocelyn Downie and others present evidence saying that things like social isolation are not factors that support MAID.

Andrew Lawton: Your written testimony says that MAID, if expanded to people with mental illness as a sole criterion, “would not expand access to individuals recently diagnosed with a mental illness or those who have never received treatment for their mental illness.”

Where in the law we're reviewing is that spelled out precisely?

Helen Long: That is not in the legislation, but it would form part of the eligibility criteria in the assessment a clinician provides.

Andrew Lawton: Would you support a reform that puts this in ink in the legislation?

Helen Long: Generally speaking, that is not detailed in legislation. It's in practice standards. It's in guidelines. It's in college materials. It's in training modules. It's in all the other pieces that exist.

Andrew Lawton: It doesn't exist—the clarity you say is there.

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

Mr. Fragiskatos, go ahead for three minutes.

Peter Fragiskatos (London Centre, Lib.): Thank you very much, Chair.

This is the first meeting I'm attending as a new member on the Liberal side. I look forward to working with colleagues on the Conservative side, with the Bloc, of course, and with senators. It's a very important subject, to say the least.

On that note, I'll turn to Ms. Long.

I'll make reference to the first panellist we had. It really left an impression on me when we had a witness say that, in the vast majority of cases they've observed—they are an expert on the subject making particular reference to the Netherlands but going beyond that, as well—those seeking medical assistance in dying for reasons of mental illness are “living in poverty”. They're traumatized. They are living in deep trauma. That left an impression, I think, on all of us. It implies many things about this debate.

How do you take that comment, Ms. Long?

● (2035)

Helen Long: I think we all recognize that we could do more to support individuals living in poverty or needing access to mental health supports. In that same panel, you heard testimony that we are able to assess and consider those factors in assessing for MAID.

Peter Fragiskatos: That's fine, but I also heard in that testimony when something seems irremediable and the door towards a cure seems absolutely shut, suddenly it can open.

Mr. Schadenberg, can you touch on this? There is a lot to be said about those living with mental illness and not having any hope, but suddenly, a door of hope can open. What would it mean if the government and parliamentarians endorsed a view of medical assistance in dying that would allow for this to happen?

Alexander Schadenberg: When the debate on this issue began again, we asked people to send us stories of their personal experiences. I received a story from a person named Andrea, who spoke about living with significant mental illness between the years of 2011 and 2016. She was in a psych ward six times, and she would have wanted MAID if it had been available to her. It was not available, and she's happy to be alive.

Someone named Catherine sent us a similar letter about attempting suicide several times. She truly was treated as if she were a hard case, irremediable, but then something changed in her life. She's now married and stable. She has a child. She's fully employed, and she's happy to be alive.

The Joint Chair (Marcus Powlowski): Thank you.

[*Translation*]

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

Claude DeBellefeuille: Thank you, Mr. Chair.

Ms. Long, we know that there are cases pending and legal proceedings involving people with mental illness who want medical assistance in dying. By deciding not to expand access to it, or at least to continue the discussion, we're basically giving patients the burden of having the legislation clarified. I find this quite unfair.

Do you think that we could ask the Supreme Court whether, in its opinion, discrimination against people with a mental illness when it comes to access to medical assistance in dying respects the spirit of the charter?

Before making a decision on whether the sunset clause should continue, do you think that we should ask the Supreme Court for its opinion?

[*English*]

Helen Long: That step was not taken when the law came out. In fact, the government at the time acknowledged that it felt it would be overruled by the Supreme Court, but it's certainly a step that could be taken.

In an earlier meeting, I think Senator Dalphond made the point that it places the burden on patients. That is certainly true and perhaps not where the burden should be.

[*Translation*]

Claude DeBellefeuille: We all know examples of people who ultimately decided to end their lives because they could no longer tolerate living, despite all the family and psychiatric support.

What would you say to people in this type of situation, should the committee decide to remove this option from the legislation?

[*English*]

Helen Long: Yes, it's very difficult. We have done a lot of work through ASIST, safeTALK and intervention training. We make referrals on a regular basis to 988 mental health resources across the country. With very limited success, we tried to work with a number of organizations to set up warm hand-offs for those individuals who truly need support and who are not really seeking access to MAID. We make wellness calls on occasion, when we have to.

I would urge the committee, with whatever recommendation you make, to provide clarity and provide a timeline as far as possible before the March deadline. There are individuals who have put a lot of hope in this. At each deadline, we have seen losses because of the frustration, upset, disappointment and distress.

● (2040)

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

Senator Moodie, go ahead for two minutes.

Hon. Rosemary Moodie: My question is for Ms. Long.

As a committee and in this current process, I believe we have failed to give voice to individuals with lived experience, such as Ms. Brosseau, who you mentioned earlier in your testimony. By the way, many of us put her name forward to be a potential witness.

Tamara Jansen: I have a point of order. We've had quite a few people with lived experience. We've mentioned it before. Let's set the record straight.

Hon. Rosemary Moodie: Excuse me. Are you giving the floor to...?

The Joint Chair (Marcus Powlowski): I'm sorry, who is...?

Hon. Rosemary Moodie: Can we stop the clock, please?

The Joint Chair (Marcus Powlowski): Madam Jansen, you have a point of order.

Tamara Jansen: On a point of order, I'm setting the record straight. We've had plenty of lived experience. We have one woman here as we speak.

The Joint Chair (Marcus Powlowski): Senator Moodie—

Hon. Rosemary Moodie: I was about to explain why her lived experience was distinctly different.

The Joint Chair (Marcus Powlowski): You have the floor, Senator Moodie.

Hon. Rosemary Moodie: Thank you.

Ms. Brosseau is a person who has publicly spoken about her illness, about the intervention she has had in her life, and about her readiness to seek MAID.

The question I have for Ms. Long is, as a person who interacts with individuals such as Ms. Brosseau, how is she feeling and how are others like her feeling when we are not listening to their voices when, in fact, we are listening to voices of parents and siblings and other individuals in this committee?

Helen Long: I would first clarify that the people with lived experience who have been missing from these hearings are those who but for the exclusion criteria would be eligible and approved for MAID. Ms. Brosseau has actually gone through two MAID assessments in order to proceed with her lawsuit, so we know that she is someone who may be considered eligible.

This is actually a note Claire gave me yesterday. It says:

> I am deeply disappointed and I must admit, somewhat shocked about what is happening at the...committee. [I know that] “there are only so many hours in a day” to hear testimony but I would have thought they would want to listen to a few minutes from someone with lived experience in addition to the...people they have heard from who are opposed. I have offered to appear before the committee to provide my perspective as a person with lived experience of mental illness who is prevented from accessing MAID. We so often hear the expression “nothing about us without us” and yet they have refused to hear from any people who are harmed from the exclusion—

Tamara Jansen: Can I raise another point of order?

We had every opportunity—senators, everybody—to see the witness list, and now we're suggesting that we didn't.

The Joint Chair (Marcus Powlowski): I don't think it's a point of order.

Mr. Cooper, go ahead with a point of order that may or may not be a point of order.

Michael Cooper: On the same point of order, these senators have repeatedly asserted that somehow the witness list was unrepresentative.

I would remind Senator Moodie that as of the last meeting, 13 of the 38 witnesses that were heard at this committee came from those senators.

The Joint Chair (Marcus Powlowski): Thank you. It wasn't a point of order.

Senator Moodie, you only have three seconds left.

Hon. Rosemary Moodie: [*Inaudible—Editor*] look at the media reports on this.

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

Lastly, we go to Senator Wells for three minutes.

Hon. Kristopher Wells: Ms. Long, you mentioned earlier three academics and some of the research, particularly Dr. James Downar, who's here in Ottawa and who's done empirical research on social vulnerabilities. I'm hoping that, to support your testimony, you would send in those research articles so they can be part of the official record here for our deliberations.

Helen Long: Yes, absolutely.

Hon. Kristopher Wells: Thank you.

Our committee has heard very alarming testimony from multiple witnesses, primarily from witnesses who oppose MAID for MI-SUMC, of individual cases of unlawful MAID requests that were approved. These were cases such as an individual seeking MAID because of a broken heart or shopping around for a physician who would give them MAID, although none of these witnesses were able to follow up with any action they took to bring these cases to appropriate authorities and prosecute these cases.

Based on your experience with people going through the process of requesting MAID, do you feel as though the current safeguards that are in place to protect against unlawful access to MAID are working?

● (2045)

Helen Long: Yes, I do. We hear from people on their journey and from families following the journey. Honestly, the biggest challenges we hear about are those where there are barriers in terms of information, access, referrals and that type of thing.

Hon. Kristopher Wells: Great. Thank you.

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

We will briefly suspend to go in camera.

[*Proceedings continue in camera*]

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