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Final Report of the Expert Panel on

MAiD AND MENTAL ILLNESS

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LETTER TO THE MINISTERS

May 6, 2022

The Honourable Jean-Yves Duclos
Minister of Health

The Honourable David Lametti
Minister of Justice and Attorney General of Canada

Dear Ministers,

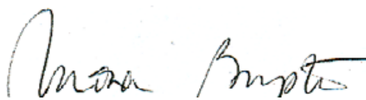
We are pleased to submit the final report of the Expert Panel on MAiD and Mental Illness for your consideration.

It is a privilege to contribute to Canada's ongoing discussions about medical assistance in dying (MAiD). We are aware these discussions can be contentious, and on the specific topic of MAiD for mental illness there is a full spectrum of views. Although our mandate was not to debate whether access to MAiD for mental illness should be allowed, we took very seriously those arguments. These arguments were thoroughly discussed and informed the development of our recommendations.

No system of safeguards, protocols and guidance will satisfy everyone because people differ in terms of how they make the compromises between the competing values at the heart of this practice. After careful consideration of the proposals made by Canadian groups and organizations and of international experience, we have tried to devise a set of measures to support—at the same time—safety, autonomy and equity.

The recommendations contained within this report are based on the collective knowledge and experiences of members of the Panel. As authors, we unanimously support these recommendations.

We hope that our work will make a positive contribution to the evolution of MAiD policy and practice.



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GLOSSARY OF TERMS AND ABBREVIATIONS

***Act respecting end-of-life care*:** Québec's legislation outlining the eligibility and criteria for medical aid in dying in the province.

AMPQ (Association des médecins psychiatres du Québec): An obligatory professional association for Québec psychiatrists who are reimbursed by the provincial health insurance scheme.

Assisted suicide: In international regimes, assisted suicide refers to the act of intentionally ending one's life with the assistance of another person who provides the knowledge, means, or both, to do so.

Benelux: Refers to the countries of Belgium, the Netherlands, and Luxembourg.

Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*: Canada's first legislation on MAiD established eligibility criteria and safeguards for the assessment and provision of MAiD; received Royal Assent on June 17, 2016.

Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*: The second set of amendments to the *Criminal Code* respecting extended eligibility and significantly modified the applicable safeguards; received Royal Assent on March 17, 2021.

CAMAP (Canadian Association of MAiD Assessors and Providers): A voluntary professional association primarily composed of physicians and nurse practitioners who provide MAiD and assess requesters.

Capacity: The legal status of being able to provide informed consent for or refusal of healthcare interventions.

***Carter* decision:** The landmark Supreme Court of Canada decision which struck down the provisions of the *Criminal Code* that prohibited a medical practitioner from aiding a person to die by suicide by providing them with the necessary medication, or from directly causing their death at their request.

CCA (Council of Canadian Academies): A not-for-profit organization that convenes expert panels to assess the evidence on complex scientific topics of public interest.

Charter: *Canadian Charter of Rights and Freedoms*.

CMA (Canadian Medical Association): A voluntary, professional association representing Canadian physicians.

CMPA (Canadian Medical Protective Association): A voluntary association providing practice insurance and legal services to physicians.

CMQ (Collège des Médecins du Québec): The medical regulatory authority in Québec.

CPA (Canadian Psychiatric Association): A voluntary professional association representing Canadian psychiatrists.

Criminal Code: The statute that contains the federal MAiD framework. It defines medical assistance in dying (MAiD), states who may provide it, and provides exemptions to physicians and nurse practitioners from the offences of counselling or aiding suicide, culpable homicide, and administering a noxious thing so that they may lawfully provide MAiD to eligible persons. It lays out the MAiD eligibility criteria and procedural safeguards that must be followed by practitioners.

CSC: The Correctional Service of Canada is the federal government agency responsible for administering sentences of a term of two years or more, as imposed by the courts. CSC is responsible for managing institutions of various security levels, and supervising offenders under conditional release in the community. Individuals under supervision of CSC must be provided with essential health care that conforms to professionally accepted standards. CSC has five regional treatment centres across Canada to care for inmates with serious mental health conditions.

DSM-5: Refers to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, currently in its fifth revision.

End-of-life criterion: In order to be found eligible to receive MAiD under Québec's *Act respecting end-of-life care,* a person needed to be at the "end-of-life". This provision was declared invalid in the 2019 *Truchon* decision.

Euthanasia: In international regimes, euthanasia refers to the intentional termination of the life of a person, by another person, in order to relieve the first person's suffering.

Federal MAiD Monitoring System: The Federal MAiD Monitoring System collects information from physicians, nurse practitioners, and pharmacists on all written requests for, and provisions of, MAiD. Health Canada produces an annual report using the information collected through this system.

FMRAC (Federation of Medical Regulatory Authorities of Canada): FMRAC is the umbrella organization for the provincial and territorial medical regulators.

Health professional regulatory authorities: Responsible for ensuring that regulated health professionals provide health services safely and in the public interest. This includes, for example, setting standards of practice, investigating complaints, and taking disciplinary action, where appropriate.

ICD-11: The World Health Organization's International Classification of Diseases, currently in its 11th revision.

Informed consent: A person must provide informed consent prior to receiving a healthcare intervention, including MAiD. To provide informed consent a person must be capable, they must have been given an adequate explanation about the nature of the proposed intervention and its anticipated outcome as well as the significant risks involved and alternatives available, and the consent must be voluntary.

MacCAT-T: MacArthur Competence Test for Treatment.

MAiD: Medical Assistance in Dying—an umbrella term that includes clinician-administered assistance in dying and self-administered assistance in dying. These practices include what is called euthanasia (clinician-administered) and assisted suicide (self-administered) in other jurisdictions.

MAiD MD-SUMC: Medical assistance in dying where a mental disorder (see definition below) is the sole underlying medical condition.

MAiD MI-SUMC: Medical assistance in dying where a mental illness (see definition below) is the sole underlying medical condition.

Mental disorder: The DSM-5 states that a mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or development processes underlying mental functioning.

Mental illness: Refers to a subset of mental disorders, but lacks a standard clinical definition. This is the term used in Bill C-7 and associated materials (e.g., legislative background and Charter Statement).

NVvP: Nederlandse Vereniging voor Psychiatrie (Dutch Psychiatric Association).

Oversight: Oversight refers to the review of individual cases to determine whether there has been compliance with applicable laws. The oversight of MAiD is the responsibility of provinces and territories in partnership with their respective professional regulatory bodies.

Panel: Expert Panel on MAiD and Mental Illness.

Professional association: A non-governmental organization representing specific types or groups of professionals. Depending on their mandate, health professional associations may seek to advance the professional interests of their members, advocate for patients, develop clinical practice guidelines, and support research and educational activities for their members.

Protocols and guidance: Non-legislative mechanisms such as standards of practice promulgated by healthcare regulatory authorities, practice guidelines developed by professional associations, or institutional policies created by local and regional health authorities.

QCSC: Superior Court of Québec.

Quality assurance: Refers to activities and programs intended to identify problems or issues and provide feedback to support learning and system improvements.

RFND: Reasonably foreseeable natural death.

Non-RFND: Natural death is not reasonably foreseeable.

RTE: Regionale Toetsingscommissies Euthanasie—refers to the regional euthanasia review committees in the Netherlands.

Safeguards: Refers to protective legislative measures enacted through the *Criminal Code*.

SCC: Supreme Court of Canada.

Track 1: Refers to a request for MAiD made by a person whose death is "reasonably foreseeable." These requests are subject to the original safeguards outlined in the former legislation on MAiD (Bill C-14) with some modifications resulting from the passage of Bill C-7 (e.g., elimination of the 10-day reflection period, requirement for one rather than two independent witnesses).

Track 2: Refers to a request for MAiD made by a person whose natural death **is not** "reasonably foreseeable." These requests are subject to additional safeguards, such as a minimum 90-day assessment period, consultation with a practitioner that has expertise in the person's condition if the two assessors do not have this expertise, and an offer of information on available means to alleviate suffering.

***Truchon* decision:** Declared invalid the MAiD eligibility requirement that a person's natural death must be reasonably foreseeable under federal legislation or that a person be at the "end of life" under Quebec legislation.

VVP: Vlaamse Vereniging voor Psychiatrie (Flemish Psychiatric Association).

EXECUTIVE SUMMARY

Introduction: Context, Mandate and Scope

On March 17, 2021, Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)* received Royal Assent and came into force. This Bill amended Canada's original 2016 MAiD legislation, Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. The effect of Bill C-7 was to extend eligibility for medical assistance in dying (MAiD) to individuals with a grievous and irremediable medical condition whose natural death is not reasonably foreseeable and to add certain legislative safeguards for this group of requesters.

Bill C-7 temporarily excludes, until March 17, 2023, eligibility for individuals with a mental illness as their sole underlying medical condition. To support an objective and informed approach to the issue, Bill C-7 required the Minister of Health and the Minister of Justice to initiate an independent expert review "respecting recommended protocols, guidance and safeguards to apply to requests for medical assistance in dying by persons who have a mental illness."

The Expert Panel on MAiD and Mental Illness (the Panel) was formed in August 2021 to undertake this review. The Panel's Terms of Reference (Appendix A), indicated that its role was not to debate whether or not persons with a mental illness as their sole underlying medical condition should be eligible for MAiD. Nonetheless, the Panel considered very carefully the concerns of researchers, clinicians and stakeholders who question the advisability of allowing access to MAiD by individuals with mental illness.

Early in its deliberations, the Panel was confronted with two challenges related to the scope of its work.

First, the Panel's mandate uses the term 'mental illness.' However, the term 'mental illness' does not have a standard definition. The Panel was concerned that referring to 'mental illness' would create confusion, as it would be unclear to whom the Panel's advice applies. A comprehensive review of the knowledge available on the topic of MAiD for mental illness required by the 2016 MAiD legislation (Council of Canadian Academies, 2018) recommended the use of the standard clinical term, 'mental disorder'. Therefore, throughout this report, the Panel uses 'mental disorder' as that is the term used in both major diagnostic classification schemes relied upon in Canadian psychiatric practice: the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization's International Classification of Diseases (ICD).

Second, the Panel believes that the concerns raised in the debate on MAiD MD-SUMC (and discussed in greater detail below) do not apply ***only*** to people with 'mental illness' nor to ***all*** people with 'mental illness.' While we acknowledge that our mandate refers only to mental illness, the Panel believes that its recommendations for safeguards, protocols, and guidance should apply to all clinical situations in which any, several or all of these major concerns arise—incurability, irreversibility, capacity, suicidality, and/or the impact of structural vulnerabilities—regardless of the requester's diagnoses.

The Major Concerns About MAiD MD-SUMC

Incurability and irreversibility

The evolution of many mental disorders, like some other chronic conditions, is difficult to predict for a given individual. There is limited knowledge about the long-term prognosis for many conditions, and it is difficult, if not impossible, for clinicians to make accurate predictions about the future for an individual patient. What clinicians can do is evaluate the severity of a person's condition in the present based on the evolution of the condition up until that point, and based on past response to treatments and support services.

In terms of MAiD eligibility, having to establish incurability and irreversibility on the basis of the evolution and response to past interventions is necessary—and accepted—for other medical conditions such as chronic pain. This is also the approach adopted by psychiatrists assessing requests for assisted dying in the Netherlands and Belgium (where MAiD for mental disorders is permitted).

Capacity

In Canada, a patient must give informed consent to any proposed healthcare intervention, including MAiD. In general, the law presumes that all adults—including those with mental disorders—have decision-making capacity, that is, the ability to provide informed consent or refusal to the healthcare interventions proposed to them.

Assessing capacity can be difficult, particularly in situations in which symptoms of a person's condition or their life experiences could subtly influence their ability to understand and appreciate the decision they are to make. The Panel notes that this judgment can be equally challenging for other serious medical decisions such as whether to withdraw lifesaving treatment and accepting or rejecting burdensome treatments. In other areas of practice, difficulties in assessing capacity are not resolved by refusing to permit the intervention to all persons or a subgroup of persons. Rather, when the assessment is so difficult or uncertain that the clinicians involved cannot establish that a specific individual is capable of giving informed consent, the intervention is not provided to that individual.

Suicidality

In considering MAiD requests for persons who have mental disorders, it must be recognized that thoughts, plans and actions to bring about one's death may also be a symptom of the very condition which is the basis for a request for MAiD.

While there is a strong association between completed suicide and a diagnosed mental disorder, the vast majority of people with mental disorders do not complete suicide. Therefore, the presence of a mental disorder in and of itself does not necessarily mean that the person is at significant risk of attempted or completed suicide. Conversely, a person may express suicidality even if they do not have a diagnosis associated with suicide (or any mental disorder at all).

Even before the era of MAiD, clinicians were confronted with situations in which patients made decisions that would certainly or probably lead to their deaths, whether these were informed refusals of life-sustaining or life-saving treatments, non-adherence to life-sustaining treatments, or repeated engagement in high-risk behaviours. Such situations may also raise the question of suicidality. In any situation where suicidality is a concern, the clinician must adopt three complementary perspectives: consider a person's capacity to give informed consent or refusal of care, determine whether suicide prevention interventions—including involuntary ones—should be activated, and offer other types of interventions which may be helpful to the person.

Clinicians do not always prevent people—nor are they entitled to—from making life-ending decisions. In situations where there is no acute crisis and the person is capable to make the decision, clinicians will encourage preservation of life through all therapeutic mechanisms available, but do not go so far as to prevent a person from acting in every situation. This approach is consistent with existing legal and ethical norms concerning informed consent, decision-making capacity, and involuntary hospitalization for mental disorders.

Intersection of structural vulnerability, mental disorder and MAiD

Structural vulnerability refers to the impacts of the interaction of demographic attributes (i.e., sex, gender, socioeconomic status, race/ethnicity), with assumed or attributed statuses related to one's position in prevailing social, cultural, and political hierarchies. Negative perceptions of these characteristics may lead to difficult social circumstances such as unstable housing and lack of employment opportunities. It can also affect self-perception and have an impact on how people interact with and are treated by health care systems. These types of circumstances can influence suffering and contribute to viewing death as one's only option.

At the same time, persons with mental disorders may be assumed, incorrectly, to be incapable of consenting to receive MAiD. Their suffering may not be visible and the severity or unbearableness of it may be underestimated. A request may be taken as evidence the person is suicidal and even lead to coercive measures such as involuntary hospitalization.

That MAiD requests may mask profound unmet needs or conversely, that such requests may not be received with the seriousness they deserve, has been raised with respect to several historically marginalized populations (e.g., racialized groups, Indigenous peoples, persons living with disabilities, and sexual orientation and gender minorities). In the course of assessing a request for MAiD—regardless of the requester's diagnoses—a clinician must carefully consider whether the person's circumstances are a function of systemic inequality.

The Panel acknowledges the seriousness of the above concerns, and has carefully considered each of these questions in formulating its recommendations.

Recommendations

The Panel's work culminated in nineteen recommendations that, in its view, can be fulfilled without adding new legislative safeguards to the *Criminal Code*. The Panel found that the existing MAiD eligibility criteria and safeguards buttressed by existing laws, standards, and practices in related areas of healthcare can provide an adequate structure for MAiD MD-SUMC so long as they are interpreted appropriately to take into consideration the specificity of mental disorders.

Ultimately, the Panel agreed on a set of recommendations that are internally consistent and interdependent. They lay out a broad set of principles to structure the practice of MAiD MD-SUMC. As MAiD is an area of concurrent jurisdiction, some recommendations will require concerted action by both federal and provincial/territorial orders of government. Others require collaborations by actors such as regulators and professional associations.

The Panel's recommendations are summarized below:

MAiD Practice Standards

RECOMMENDATION 1: DEVELOPMENT OF MAiD PRACTICE STANDARDS

The federal, provincial and territorial governments should facilitate the collaboration of physician and nurse regulatory bodies in the development of Standards of Practice for physicians and nurse practitioners for the assessment of MAiD requests in situations that raise questions about incurability, irreversibility, capacity, suicidality, and the impact of structural vulnerabilities. These standards should elaborate upon the subject matter of recommendations 2–13.

Interpreting Grievous and Irremediable Medical Condition

RECOMMENDATION 2: ESTABLISHING INCURABILITY

MAiD assessors should establish incurability with reference to treatment attempts made up to that point, outcomes of those treatments, and severity and duration of illness, disease or disability.

It is not possible to provide fixed rules for how many treatment attempts, how many kinds of treatments, and over what period of time as this will vary according to the nature and severity of medical conditions the person has and their overall health status. This must be assessed on a case-by-case basis.

The Panel is of the view that the requester and assessors must come to a shared understanding that the person has a serious and incurable illness, disease or disability. As with many chronic conditions, the incurability of a mental disorder cannot be established in the absence of multiple attempts at interventions with therapeutic aims.

RECOMMENDATION 3: ESTABLISHING IRREVERSIBILITY

MAiD assessors should establish irreversibility with reference to interventions tried that are designed to improve function, including: recognized rehabilitative and supportive measures that have been tried up to that point, outcomes of those interventions, and the duration of decline.

It is not possible to provide fixed rules for how many attempts at interventions, how many types of interventions, and over how much time, as this will vary according to a requester's baseline function as well as life goals. Therefore, this must be assessed on a case-by-case basis.

The Panel is of the view that the requester and assessors must come to a shared understanding that the person is in an advanced state of irreversible decline in capability.

RECOMMENDATION 4: UNDERSTANDING ENDURING AND INTOLERABLE SUFFERING

MAiD assessors should come to an understanding with the requester that the illness, disease or disability or functional decline causes the requester enduring and intolerable physical or psychological suffering.

Vulnerabilities

RECOMMENDATION 5: COMPREHENSIVE CAPACITY ASSESSMENTS

MAiD assessors should undertake thorough and, where appropriate, serial assessments of a requester's decision-making capacity in accordance with clinical standards and legal criteria. These assessments should be consistent with approaches laid out in standardized capacity evaluation tools.

RECOMMENDATION 6: MEANS AVAILABLE TO RELIEVE SUFFERING

To ensure all requesters have access to the fullest possible range of social supports which could potentially contribute to reducing suffering, the Panel recommends that 'community services' in Track 2 Safeguard 241.2(3.1)(g) should be interpreted as including housing and income supports as means available to relieve suffering and should be offered to MAiD requesters, where appropriate.

RECOMMENDATION 7: INTERPRETATION OF TRACK 2 SAFEGUARD 241.2(3.1)(h) THE PERSON HAS GIVEN SERIOUS CONSIDERATION TO THOSE MEANS

Serious consideration should be interpreted to mean genuine openness to the means available to relieve suffering and how they could make a difference in the person's life.

RECOMMENDATION 8: CONSISTENCY, DURABILITY, AND WELL-CONSIDERED NATURE OF A MAiD REQUEST

Assessors should ensure that the requester's wish for death is consistent with the person's values and beliefs, unambiguous and rationally considered during a period of stability, not during a period of crisis.

RECOMMENDATION 9: SITUATIONS OF INVOLUNTARINESS

Persons in situations of involuntariness for periods shorter than six months should be assessed following this period to minimize the potential contribution of the involuntariness on the request for MAiD. For those who are repeatedly or continuously in situations of involuntariness, (e.g., six months or longer, or repeated periods of

less than six months), the institutions responsible for the person should ensure that assessments for MAiD are performed by assessors who do not work within or are associated with the institution.

Assessment Process

RECOMMENDATION 10: INDEPENDENT ASSESSOR WITH EXPERTISE

The requester should be assessed by at least one assessor with expertise in the condition(s). In cases involving MAiD MD-SUMC, the assessor with expertise in the condition should be a psychiatrist independent from the treating team/provider. Assessors with expertise in the person's condition(s) should review the diagnosis, and ensure the requester is aware of all reasonable options for treatment and has given them serious consideration.

RECOMMENDATION 11: INVOLVEMENT OF OTHER HEALTHCARE PROFESSIONALS

Assessors should involve medical subspecialists and other healthcare professionals for consultations and additional expertise where necessary.

RECOMMENDATION 12: DISCUSSION WITH TREATING TEAM AND COLLATERAL INFORMATION

RECOMMENDATION 12(a)

If the requester's primary healthcare provider is not one of the assessors, assessors should obtain input from that person. When the requester's clinical care is shared by members of a multidisciplinary healthcare team, assessors should solicit their input as well.

RECOMMENDATION 12(b)

With a requester's consent, assessors and providers shall obtain collateral information relevant to eligibility and capacity assessment. This should include reviewing medical records, prior MAiD assessments, and discussions with family members or significant others. Care must be taken to determine that obtaining collateral information will not be harmful to the requester.

RECOMMENDATION 13: CHALLENGING INTERPERSONAL DYNAMICS

Assessors and providers should be self-reflective and examine their reactions to those they assess. If their reactions compromise their ability to carry out the assessment in accordance with professional norms, they should seek supervision from mentors and colleagues, and/or discontinue involvement in the assessment process. The practitioner should adhere to any local policies concerning withdrawal from a MAiD assessment and onward referral.

Implementation

RECOMMENDATION 14: CONSULTATIONS WITH FIRST NATIONS, INUIT AND MÉTIS PEOPLES

Consultation between health regulatory bodies in each province and territory with First Nations, Métis, and Inuit peoples must aim to create practice standards with respect to MAiD MD-SUMC, and MAiD more generally, that incorporate Indigenous perspectives and are relevant to their communities.

RECOMMENDATION 15: TRAINING OF ASSESSORS AND PROVIDERS IN SPECIALIZED TOPICS

To support consistent application of the law and to ensure high quality and culturally sensitive care, assessors and providers should participate in training opportunities that address topics of particular salience to MAiD MD-SUMC. These include, but are not limited to: capacity assessment, trauma-informed care and cultural safety.

RECOMMENDATION 16: PROSPECTIVE OVERSIGHT

Given its concurrent jurisdiction in relation to MAiD, the federal government should play an active role in supporting the development of a model of prospective oversight for all or some Track 2 cases that could be adapted by provinces and territories.

RECOMMENDATION 17: CASE-BASED QUALITY ASSURANCE AND EDUCATION

The federal government should play an active role in supporting the development of provincial/territorial systems of MAiD case review for educational and quality improvement purposes.

RECOMMENDATION 18: MODIFICATIONS TO DATA COLLECTION UNDER THE FEDERAL MAiD MONITORING SYSTEM

Data related to specific topics (eligibility, supported decision-making, means available to relieve suffering, refusal of means available, and residence and legal status) should be collected in the MAiD monitoring system in addition to data already collected under the 2018 Regulations. These data can be used to assess whether key areas of concern raised about MAiD MD-SUMC and complex Track 2 cases discussed in this report are being addressed by the clinical practices recommended.

RECOMMENDATION 19: PERIODIC, FEDERALLY FUNDED RESEARCH

The federal government should fund both targeted and investigator-initiated periodic research on questions relating to the practice of MAiD (including but not only MAiD MD-SUMC).

1.0 INTRODUCTION AND BACKGROUND

1.1 Panel Mandate

On March 17, 2021, Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)* received Royal Assent and came into force. This Bill amended Canada's original 2016 MAiD legislation, Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*. Bill C-7 includes three provisions with relevance to MAiD for persons with mental illness. First, it says that mental illness is not an illness, disease or disability for the purposes of the MAiD eligibility criterion of a "serious and incurable illness, disease or disability" (Parliament of Canada, 2021). This statement has the effect of excluding the majority of persons whose mental illness is their sole underlying medical condition (SUMC) from eligibility for MAiD. Second, this exclusion is to be automatically repealed on March 17, 2023. Third, it requires the Ministers of Health and Justice to "cause an independent review to be carried out by experts respecting recommended protocols, guidance and safeguards to apply to requests made for medical assistance in dying by persons who have a mental illness" (Parliament of Canada, 2021).

The Expert Panel on MAiD and Mental Illness (the Panel) was established by the federal government in August 2021. In its Terms of Reference (Appendix A) the Panel was instructed that its role was not to debate whether or not persons with a mental illness as their SUMC should be eligible for MAiD.

The Panel noted the arguments made by some authors that access to MAiD when a mental illness is the SUMC (MAiD MI-SUMC) should be permitted only if there is evidence that the benefits outweigh its harms, and that there is no such evidence at present (Sinyor & Schaffer, 2020). For these authors, no safeguards, protocols or guidance can be adequate to structure this practice in the absence of such evidence, and, therefore, one possible outcome is that the Panel cannot fulfill its mandate.

The Panel considered this possibility but did not arrive at this conclusion. The authors referred to above assume that death when future recovery is possible is a harm, and continued life with suffering is a benefit. The fact that there is uncertainty about the future is not a risk they are willing to assume. However, in permitting MAiD, Canadian society no longer requires everyone to accept that life is a benefit in all circumstances. When it is, and when it is not, is a question for the individual requester according to their values and in those circumstances permitted by law. There is no scientific evidence that can tell a person how much risk is the right amount of risk to assume. A small number of individuals will come to the conclusion that despite these uncertainties, they wish to request MAiD. That is why the Panel has not been moved away from its mandate and has recommended measures to ensure that these individuals make such decisions voluntarily, capably, and after extensive experience of illness and having received high quality care.

1.2 Panel Process

The Panel began its work on August 26, 2021, holding the first of fourteen biweekly Panel meetings. The Chair and Vice-Chair determined that the work of the Panel would be best achieved by forming subgroups tasked with discussing one of three major subject areas relevant to requests for MAiD and mental illness:

1. interpretation of the phrase 'grievous and irremediable medical condition';
2. assessment of decision-making (including capacity, voluntariness, and suicidality); and,
3. social determinants of health.

The subgroups reported back to the whole Panel having identified the main issues relating to their topics along with suggestions for recommendations. The Panel discussed these issues and suggestions in light of Bill C-7 (particularly its new 'Track 2' safeguards[1]), court decisions related to MAiD, current MAiD assessment practices and experience, mental health care resources, arguments raised in academic literature, experience and practices in Benelux countries and Switzerland, and perspectives of potential requesters, including people with lived experience and those from historically marginalized communities, particularly Indigenous peoples, persons with disabilities, and incarcerated persons.

[1] Track 2 safeguards apply to persons whose natural deaths are not reasonably foreseeable. MAiD access for such persons is one of the changes made to Canada's MAiD law through Bill C-7. For a complete description of Track 1 and Track 2 safeguards please see the table "Legislative Safeguards on Medical Assistance in Dying as Amended through Bill C-7" in Section 3.1.

The Panel's mandate did not include stakeholder or expert consultation nor did the Panel's seven month timeframe permit it. However, the Panel did make contact with a small number of organizations: the Federation of Medical Regulatory Authorities of Canada (FMRAC), the Canadian Medical Protective Association (CMPA), the Correctional Service of Canada (CSC), and Inclusion Canada[2] as well as several MAiD assessors and providers in four provinces who were willing to give feedback about their experiences with Track 2 requests. The Panel also contacted two psychiatrists in other countries with direct experience assessing, providing, and/or researching assisted dying for persons with mental illness. We made these contacts to obtain specialized information that was not otherwise accessible. We have indicated when this information informed the content of the report. Finally, the Panel received a small number of unsolicited submissions from organizations and individuals. These were circulated to all Panel members for review.

The Panel's work culminated in the recommendations contained within this report. The recommendations are based on the collective knowledge and experiences of members of the Panel. A consensus-seeking approach was adopted for the Panel's deliberations. The authors achieved unanimity in support of the recommendations.

A few explanatory notes about the text of the report are in order from the outset. While the Panel's mandate refers to MAiD for persons with mental illness, the term 'mental illness' does not have a standard definition. The fact there is no such definition risks creating confusion as it will be unclear to whom the Panel's advice applies.

In its comprehensive review of the relevant research and knowledge concerning MAiD when a mental disorder is the SUMC (MAiD MD-SUMC), the Council of Canadian Academies (CCA)[3] recommended the use of the standard clinical term, 'mental disorder.' In addition, in their communications with the Panel, both the CMPA and FMRAC underlined the importance of clear language concerning the eligibility criteria and safeguards on MAiD (CMPA, 2021c; FMRAC, 2022). FMRAC specifically stressed the importance of clinicians using standardized classification schemes for mental disorders when making diagnoses (FMRAC, 2022). Therefore, throughout this report, we use the expression 'mental disorder' utilized by both major diagnostic classification schemes relied upon in Canadian psychiatric practice: the American Psychiatric Association's

[2] Because Inclusion Canada opposes MAiD in situations where natural death is not reasonably foreseeable, the organization did not wish to provide any input about safeguards, protocols and guidance to be used in the circumstances of MAiD for mental illness.

[3] Bill C-14 directed the Minister of Justice and Minister of Health to initiate three independent reviews relating to MAiD including one concerning MAiD MI-SUMC requests. The federal government asked the CCA to undertake the reviews. The reports were tabled in Parliament in December 2018.

Diagnostic and Statistical Manual of Mental Disorders (DSM)[4] and the World Health Organization's International Classification of Diseases (ICD).[5,6] However, when we refer to statements made by the federal government or to our mandate, we will use the federal government's preferred expression 'mental illness.'

The Panel's mandate was to make recommendations, where appropriate, concerning safeguards, protocols and guidance. As these terms can be used differently depending on the context, we followed the meanings implied by Bill C-7. Safeguards, protocols and guidance are mechanisms whose goal is to ensure protection of eligible or potentially eligible requesters. Safeguards are legislated provisions found in the *Criminal Code*, while protocols and guidance refer to other mechanisms such as standards of practice promulgated by healthcare regulatory authorities, practice guidelines developed by professional associations, or institutional policies created by local and regional health authorities.

It is important to clarify what this report does not contain. The report does not lay out the debate about whether persons with mental disorders as a SUMC should have access to MAiD. This access is already provided for in law as of March 17, 2023. It does not present a systematic review of the relevant literature nor does it provide a formal legal opinion on the issue. Most importantly, the recommendations contained within this report do not represent complete or definitive practice guidelines with respect to MAiD MD-SUMC. The recommendations in the report are made with the recognition that more work will need to be undertaken by other actors—regulators, professional associations, and institutional committees—who have the content expertise to develop specific guidelines for practitioners.

This report is divided into four sections. In the first section, the Panel sets out the relevant legal and public policy context surrounding its subject matter. In the second section, the Panel discusses concerns raised about the practice of MAiD for persons with mental illness. In the third section, the Panel makes nineteen recommendations whose purpose is to address the problems identified in section two. The fourth section identifies three issues that, while in scope, require further consideration beyond the life of the Panel.

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[4] The DSM is periodically revised and updated. The current version is the fifth revision. At the time of this writing, the classification scheme is known as the DSM-5-text revisions (published online December 28, 2021 and released March 2022).

[5] Although the expression 'mental disorder' refers to all the diagnoses found within these classification schemes, we recognize that the federal government has already stated that certain conditions which are classified in these schemes, are not considered mental illness for the purposes of the exclusion clause. These include: neurocognitive or neurodevelopmental disorders, or other conditions that may affect cognitive abilities, such as dementias, autism spectrum disorders or intellectual disabilities.

[6] Similar to the DSM, the ICD is periodically revised and updated. The current version is the 11th revision which came into effect January 1, 2022.

1.3 Summary of Legal Context as it Pertains to MAiD and Mental Illness

On February 6, 2015, in *Carter v. Canada (Carter)*, the Supreme Court of Canada (SCC) struck down sections 14 and 241(b) of the *Criminal Code* which prohibited assisting a person to die (SCC, 2015).

> ***Section 241(b)*** *of the Criminal Code said that "everyone who aids or abets a person in committing suicide commits an indictable offence," and section 14 said that "no person may consent to death being inflicted on them." Together, these provisions prohibited medical assistance in dying in Canada.*

The SCC held that provisions of the *Criminal Code* preventing a capable adult with a grievous and irremediable medical condition causing enduring, intolerable, and irremediable suffering from voluntarily seeking assistance in dying from a physician[7] violated section 7 of the *Charter of Rights and Freedoms of Canada* (the *Charter*): the right to life, liberty, and security of the person and the right not to be deprived of them except in accordance with principles of fundamental justice. According to the decision, this deprivation of section 7 rights was not saved by section 1. The SCC declared sections 14 and 241(b) invalid in certain cases but suspended the declaration of invalidity for 12 months to allow the federal government time to legislate on the matter if it wished to do so. The suspension was extended for an additional four months and, during this time, persons who wished to receive MAiD were permitted to seek judicial authorization to do so if they met the eligibility criteria set out in *Carter*. During the exemption period granted by the SCC to the government, there were fifteen reported cases where requesters applied to the Superior court of their particular jurisdiction for approval of MAiD. All 15 requests were granted.[8]

[7] The terms physician assisted death and physician assisted dying were used by the Plaintiffs in the *Carter* case. The Special Joint Committee on Physician Assisted Dying (2016) recommended changing the terminology to medical assistance in dying to reflect the participation of a range of health professionals including nurses and pharmacists.

[8] *HS(Re)*, 2016 ABQB 121; *A.B. v. Canada (Attorney General)*, 2016 ONSC 1912; *Patient v. Attorney General of Canada*, 2016 MBQB 63; *A.B. v. Ontario (Attorney General)*, 2016 ONSC 2188; *A.A. (Re)*, 2016 BCSC 570; *W.V. v. Canada (Attorney General)*, 2016 ONSC 2302; *CD v. Canada (Attorney General)*, 2016 ONSC 2431; *EF v. Canada (Attorney General)*, 2016 ONSC 2790; *Canada (Attorney General) v. E.F.*, 2016 ABCA 155; *Patient 0518 v. RHA 0518, Physician A0518 and Physician C0518*, 2016 SKGB 176; *M.N. v. Canada (Attorney General)*, 2016 ONSC 3346; *I.J. v. Canada (Attorney General)*, 2016 ONSC 3380; *H.H. (Re)*, 2016 BCSC 971; *Tuckwell (Re)*, 2016 ABQB 302; *O.P. v. Canada (Attorney General)*, 2016 ONSC 3956

***In Carter**, the SCC declared that section 241(b) and section 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for:*

- *A competent adult person who clearly consents to the termination of life and*
- *Has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual and cannot be alleviated through means that are acceptable to the individual.*

In one of these requests, the Alberta Court of Appeal considered the eligibility for MAiD of a person with a mental disorder under the *Carter* criteria *(Canada (Attorney General) v F. (E.)* (Alberta Court of Appeal, 2016). E.F. had been diagnosed with severe conversion disorder (a mental disorder). The Court of first instance granted her application. Canada appealed that decision to the Alberta Court of Appeal. The Attorney General argued that E.F. was not eligible for MAiD under *Carter* because: "(1) the applicant's illness, however, severe, is not regarded as terminal; and (2) the applicant's illness has at its root a psychiatric condition."

The Court of Appeal noted the lower Court's acceptance of evidence from E.F.'s long-time attending physician that E.F. had been diagnosed with severe conversion disorder nine years previously; that she had been seen by several psychiatrists in the past, and at least one neurologist; and, she had tried several treatments, none of which succeeded in mitigating her symptoms. Her condition had remained unchanged during the previous four years. Another physician testified there were no further treatment options for E.F. that would offer hope of any improvement in her condition, declaring E.F.'s condition to be irremediable. A psychiatrist was asked to review E.F.'s medical record.[9] The court referenced the psychiatrist's opinion which stated "that the applicant is suffering intolerable pain and physical discomfort, that her symptoms are irremediable, and that she is capable of consent." The psychiatrist explained that although some patients with conversion disorder can be successfully treated, there are other patients who "do not respond to treatment and develop a chronic unremitting course without resolution of symptoms. The longer the symptoms persist the worse is the prognosis.

[9] As this case preceded Bill C-14, there was no established MAiD request assessment process and E.F.'s counsel did not request an assessment from the psychiatrist.

This is the case with the applicant." Ultimately, the Alberta Court of Appeal agreed that E.F. was entitled to access MAiD. In its decision, the Appeal Court referenced *Carter* noting that an exclusion for psychiatric conditions cannot be found expressly in the declaration of the SCC. The Attorney General of Canada did not seek leave to appeal to the SCC.

Meanwhile, on December 10, 2015, Québec's *Act respecting end-of-life care* came into force in that province, having been adopted in the National Assembly on June 5, 2014. Preceding the SCC's decision in Carter by eight months, Québec's Act was not a legislative response to that decision but was the result of a multi-year civil society process. Québec chose to structure assisted dying as a medical act which allowed it to pass legislation within its jurisdiction over healthcare.

***Section 26** of Quebec's Act respecting end-of-life care states that only a person that meets all of the following eligibility criteria may receive medical aid in dying:*

1. *be an **insured person** within the meaning of the Health Insurance Act*
2. *be of **full age and capable** of giving consent to care*
3. *be at the **end-of-life***
4. *suffer from a **serious and incurable illness***
5. *be in an **advanced state of irreversible decline** in capability*
6. *experience **constant and unbearable** physical or psychological suffering **which cannot be relieved** in a manner the patient deems tolerable*

The next year, in response to the 2015 *Carter* decision, Parliament passed Bill C-14 which amended the *Criminal Code* to allow MAiD. Bill C-14, which came into force on June 17, 2016, specifies the eligibility criteria and safeguards for providing MAiD, thus excluding physicians and nurse practitioners and certain other professionals assisting in the process, from criminal liability when providing MAiD in accordance with the law. As the *Criminal Code* applies everywhere in Canada, once Bill C-14 came into force, there were two laws concerning MAiD in Québec.

The eligibility criteria in the *Criminal Code* as amended by Bill C-14 are presented in the Table below:

ELIGIBILITY CRITERIA FOR MAiD INTRODUCED THROUGH BILL C-14

241.2(1) A PERSON MAY RECEIVE MEDICAL ASSISTANCE IN DYING ONLY IF THEY MEET ALL OF THE FOLLOWING CRITERIA:

(a) they are eligible — or, but for any applicable minimum period of residence or waiting period, would be eligible — for health services funded by a government in Canada;

(b) they are at least 18 years of age and capable of making decisions with respect to their health;

(c) they have a grievous and irremediable medical condition;

(d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

(e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

241.1(2) A PERSON HAS A GRIEVOUS AND IRREMEDIABLE MEDICAL CONDITION ONLY IF THEY MEET ALL OF THE FOLLOWING CRITERIA:

(a) they have a serious and incurable illness, disease or disability;

(b) they are in an advanced state of irreversible decline in capability;

(c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and

(d) **their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.**

The definition of "grievous and irremediable medical condition" did not specifically exclude mental illness. However, the final element of the definition—"natural death has become reasonably foreseeable"—made it very unlikely that most individuals with a mental disorder as a sole condition could be found eligible.[10] Nevertheless, it is possible and a small number of such cases have been reported.[11]

In light of this *de facto* limitation of access to MAiD by those with mental disorders, there continued to be debate about whether or not mental disorders were included or excluded from access to MAiD by the SCC's decision in *Carter*. In the decision itself, it is written that, "The scope of this declaration is intended to respond to the factual circumstances in this case. We make no pronouncement on other situations where physician-assisted dying may be sought"[12] (SCC, 2015, para 127). Elsewhere it is written that concerns raised in Belgium about euthanasia for persons with psychiatric disorders "…would not fall within the parameters suggested in these reasons [the *Carter* decision]." However, some observers have noted that the overall analysis in the decision suggests that the federal government's reasons for excluding people with mental disorders had already been considered and rejected in the *Carter* decision.[13]

In 2017, Jean Truchon and Nicole Gladu argued before the Superior Court of Québec (QCSC) that the eligibility criteria of reasonably foreseeable natural death—commonly referred to as RFND (Canada) and end-of-life (Québec)—violated their rights under the *Charter* (QCSC, 2019). In response, the Attorney General of Canada argued that the RFND criterion was necessary to protect vulnerable persons, among them, persons with mental disorders. Among concerns expressed were that decision-making capacity for MAiD outside the end-of-life context is too difficult to assess, and that allowing MAiD outside the parameters of RFND and end-of-life would lead people to seek MAiD as a method of completing suicide. It would also undermine suicide prevention efforts, and could lead to an increase in the rate of unassisted suicide (QCSC, 2019, s. 2.4.3).

[10] Similar reasoning applied to the end-of-life criterion in Québec.

[11] See Dr. Derryck Smith's testimony to the Standing Senate Committee on Legal and Constitutional Affairs (2021c).

[12] In the case, the plaintiffs did not have a mental disorder as a sole underlying medical condition.

[13] See for example the British Columbia Civil Liberties Association's brief on Bill C-7 to the Standing Senate Committee on Legal and Constitutional Affairs (2020).

In its September 2019 decision, the QCSC agreed with the submissions made on behalf of Truchon and Gladu and held that the RFND and end-of-life eligibility requirements were invalid. The Court explored in detail the questions of decision-making capacity for MAiD and of distinguishing MAiD from suicide (see text relating to recommendation 8 for additional information). The Court noted the lack of evidence that MAiD undermines suicide prevention or that it has increased suicide rates in jurisdictions where it is permitted outside the end-of-life context (QCSC, 2019, para 351–385). The decision also noted individuals could not be considered ineligible because they belonged to groups considered to be vulnerable. Instead any vulnerabilities experienced by MAiD requesters needed to be assessed on a case-by-case basis (QCSC, 2019, para 466).

Justice Baudouin also addressed the ongoing debate about the scope of the *Carter* decision, specifically, whether people with mental disorders as their SUMC were eligible for MAiD under this decision. She wrote, "it bears repeating that neither *Carter* nor the federal legislation excludes people with a psychiatric condition from requesting and being granted medical assistance in dying like any other Canadian who meets the legislative requirements" (QCSC, 2019, para 421).

The *Truchon* decision applied only in Québec and on its heels, Québec deemed its end-of-life criterion inoperative but did not modify its law. Justice Baudouin allowed Canada six months, until March 2020, to modify the *Criminal Code* in light of the *Truchon* decision. If after this period, the federal government had not modified its law, there would have been two MAiD regimes in Canada: in the rest of Canada, RFND would have continued to be an eligibility requirement and in Québec it would not. In February 2020, the federal government proposed further amendments to the *Criminal Code* through Bill C-7 and subsequently obtained four extensions[14] to allow the time necessary for Bill C-7 to be considered by parliamentarians. During these extension periods, the RFND eligibility criterion continued to apply everywhere in Canada including in Québec. However, residents of Québec were entitled to seek judicial authorization to receive MAiD even if their natural deaths were not reasonably foreseeable.[15]

Bill C-7 passed on March 17, 2021, bringing the *Criminal Code* in line with the *Truchon* decision. The Bill eliminated RFND as an eligibility criterion, using it instead to delineate two different groups of MAiD requesters: those whose natural deaths are

[14] In its initial decision, the Court suspended the declaration of invalidity for a period of 6 months, until March 11, 2020, and granted a constitutional exemption to the plaintiffs during the suspension period. On March 2, 2020, the Court granted the Attorney General of Canada's request that the suspension of the declaration of invalidity be extended for four months, until July 11, 2020, and subsequently granted 3 further extensions to December 18, 2020, February 26, 2021 and March 26, 2021 respectively.

[15] Nineteen authorizations were sought, all of which were granted (Health Canada, 2021)

reasonably foreseeable and those whose natural deaths are not reasonably foreseeable. Depending on the group in which a requester belongs, different safeguards apply. Requests by persons whose natural deaths are "reasonably foreseeable" (RFND) are subject to the original safeguards (Track 1) of C-14 with some modifications (for example, the elimination of the 10 day reflection period, a requirement for one rather than two independent witnesses). Requests by persons whose natural deaths are "not reasonably foreseeable" (non-RFND) are subject to a new set of safeguards (Track 2) which require, among other things a minimum 90 day assessment period and a comprehensive offer of available services to alleviate suffering.

Bill C-7 also introduced an exclusion clause for persons whose mental illness is their SUMC. This clause was amended in the Senate through a 'sunset clause' whereby the exclusion clause would expire after a fixed period of time. This amendment was accepted[16] by the federal government and appeared in the final version of Bill C-7 (Nicol & Tiedemann, 2021). The agreed period of time was two years after the coming into force of Bill C-7 and, thus, the exclusion clause will expire on March 17, 2023.

Assuming persons meet the remaining eligibility criteria, the law already permits persons with mental disorders who also have a serious and incurable physical illness, disease or disability to apply for MAiD. Effective March 17, 2023, those whose mental disorder is their SUMC will also be entitled to apply for MAiD. Canada will join a small number of countries where this practice is permitted.[17] The Panel's role is to recommend safeguards, protocols and guidance specifically for this practice.

[16] The Senate proposed an 18 month exclusion but the Government accepted the amendment with a period of 24 months.

[17] These countries include: Belgium, the Netherlands, Luxembourg, Switzerland and Germany. The legal situation in Germany is in transition but there are some assisted dying associations providing assistance. See for example: **www.sterbehilfe.de/jahresrueckblick-2021-in-zahlen.** See Appendix D for safeguards and a selection of protocols and guidance in operation in Belgium and the Netherlands. These five countries use different terminology than Canada to describe MAiD. These terms are mentioned in the Glossary.

LEGISLATIVE SAFEGUARDS ON MEDICAL ASSISTANCE IN DYING AS AMENDED THROUGH BILL C-7

TRACK 1
241.2(3) NATURAL DEATH **IS** REASONABLY FORESEEABLE (RFND)

Prior to administering medical assistance in dying, the practitioner must

(a) be of the opinion that the person meets all of the criteria set out in subsection (1);

(b) ensure that the person's request for medical assistance in dying was

- **(i)** made in writing and signed and dated by the person or by another person under subsection (4), and
- **(ii)** signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremedable medical condition;

(c) be satisfied that the request was signed and dated by the person—or by another person under subsection (4)—before an independent witness who then also signed and dated the request;

(d) ensure that the person has been informed that the person may, at any time and in any manner, withdraw their request;

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);

(f) be satisfied that they and the medical practitioner or nurse practitioner referred to in paragraph (e) are independent;

(g) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision; and

(h) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.

TRACK 2

241.2(3.1) NATURAL DEATH **IS NOT** REASONABLY FORESEEABLE (NON-RFND)

Prior to administering medical assistance in dying, the practitioner must

(a) be of the opinion that the person meets all of the criteria set out in subsection (1);

(b) ensure that the person's request for medical assistance in dying was

- **(i)** made in writing and signed and dated by the person or by another person under subsection (4), and
- **(ii)** signed and dated after the person was informed by a medical practitioner or nurse practitioner that the person has a grievous and irremediable medical condition;

(c) be satisfied that the request was signed and dated by the person—or by another person under subsection (4)—before an independent witness who then also signed and dated the request;

(d) ensure that the person has been informed that the person may, at any time and in any manner, withdraw their request;

(e) ensure that another medical practitioner or nurse practitioner has provided a written opinion confirming that the person meets all of the criteria set out in subsection (1);

- **(e.1)** if neither they nor the other medical practitioner or nurse practitioner referred to in paragraph (e) has expertise in the condition that is causing the person's suffering, ensure that they or the medical practitioner or nurse practitioner referred to in paragraph (e) consult with a medical practitioner or nurse practitioner who has that expertise and share the results of that consultation with the other practitioner;

(f) be satisfied that they and the medical practitioner or nurse practitioner referred to in paragraph (e) are independent;

(g) ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care;

(h) ensure that they and the medical practitioner or nurse practitioner referred to in paragraph (e) have discussed with the person the reasonable and available means to relieve the person's suffering and they and the medical practitioner or nurse practitioner referred to in paragraph (e) agree with the person that the person has given serious consideration to those means;

(i) ensure that there are at least 90 clear days between the day on which the first assessment under this subsection of whether the person meets the criteria set out in subsection (1) begins and the day on which medical assistance in dying is provided to them or—if the assessments have been completed and they and the medical practitioner or nurse practitioner referred to in paragraph (e) are both of the opinion that the loss of the person's capacity to provide consent to receive medical assistance in dying is imminent—any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances;

(j) if the person has difficulty communicating, take all necessary measures to provide a reliable means by which the person may understand the information that is provided to them and communicate their decision; and

(k) immediately before providing the medical assistance in dying, give the person an opportunity to withdraw their request and ensure that the person gives express consent to receive medical assistance in dying.

1.4 Policy Context

One of the challenges associated with developing a system of safeguards, protocols and guidance for MAiD in the Canadian context has to do with the country's federated structure and associated division of powers. The federal and provincial governments each have assigned spheres of legislative jurisdiction, with complex rules governing how to handle matters that fall simultaneously within both assigned spheres. MAiD is one such matter falling simultaneously within both federal and provincial legislative responsibility. It has aspects falling within the federal jurisdiction over criminal law; at the same time, it involves the regulation of the practice of medicine and nursing, a matter which falls within provincial jurisdiction. Provinces and territories delegate certain of these regulatory powers to the provincial regulatory colleges (Zarzeczny, 2017, p. 168). Professional associations and learned societies[18] are influential through the development of clinical practice guidelines and recommended practices. There are thus many parties potentially involved in the development and implementation of possible safeguards, protocols and guidance documents. Some of these measures are legislative, while others are non-legislative. Of the latter group, some may be obligatory (such as regulatory standards of practice) while others are advisory (such as clinical practice guidelines). Each instrument has its advantages and disadvantages.

A major advantage of federal legislation for MAiD is uniformity across the country, which ensures important measures, like safeguards, are implemented everywhere and in all cases. However, some desirable measures might fall within the provincial rather than federal legislative powers. An advantage of provincial legislation is that it can be tailored to reflect local needs and concerns. Variation in the organization and delivery of MAiD between provinces and territories may in certain cases, reflect appropriate responses to needs of patients, families and practitioners. Legislative uniformity,

[18] On the subject of MAiD, the Canadian Association of MAiD Assessors and Providers (CAMAP) is one such group. On the specific topic of MAiD MD-SUMC the CPA and the AMPQ have made recommendations about interpreting the eligibility criteria and assessing requests.

particularly in health care organization and delivery, may constrain appropriate flexibility in frontline care. Other matters may be better left to regulatory authorities to develop and enforce through self-regulatory processes.

The Panel has been asked for its advice by the federal government. It is clear that some types of recommendations would be impossible, or at the least extremely difficult, for the federal government to implement within Canada's federal structure. The Panel has endeavoured to keep these limitations in mind in reaching its recommendations.

The Panel has also noted the existing federal law contains a structure of safeguards. The current structure already applies to persons who have mental disorders but whose MAiD request is based on another medical condition. Our point of departure has been to reflect carefully on this structure in order to determine whether it should be modified or left unchanged but interpreted in a specific manner appropriate to requesters with mental disorders as their SUMC. To the extent that existing mechanisms are appropriate, it is likely to be preferable to supplement them as needed rather than to craft an entirely new set of mechanisms for requesters with mental disorders as the SUMC that would run in parallel with the existing system.

Ultimately, the Panel agreed to a set of recommendations that are internally consistent and interdependent. They are intended to lay out a broad set of principles to structure the practice of MAiD MD-SUMC. Their implementation and further elaboration will require concerted action at federal and provincial-territorial levels, as well as actions by regulatory colleges and expert professional bodies. As with any practice, new or unanticipated situations will arise for which local authorities may also need to develop policies.

The Panel agreed

to a set of recommendations that are internally consistent and interdependent. They are intended to lay out a broad set of principles to structure the practice of MAiD MD-SUMC. Their implementation and further elaboration will require concerted action at federal and provincial-territorial levels, as well as actions by regulatory colleges and expert professional bodies.

1.5 First Nations, Inuit, and Métis Peoples

Indigenous peoples in Canada have unique perspectives on death which need to be considered in the context of the emergence of MAiD including MAiD MD-SUMC. However, engagement with Indigenous peoples in Canada concerning MAiD has yet to occur.[19]

Through the harmful policies and practices of colonization, such as residential schools, and through legislation, the federal government has a history of causing harm to First Nations, Inuit, and Métis peoples. Compared to the non-Indigenous Canadian population, a disproportionate number of Indigenous people live in poverty, have inadequate housing, a lack of clean drinking water and have limited access to education and health care. Anti-Indigenous racism is also widespread in Canada's health care system (Turpel-Lafond, 2020). As a result of the creation of laws that provide access to MAiD, concerns have been raised by Indigenous leaders and communities that it is easier for people in their communities to access a way to die than to access the resources they need to live well.

At the same time, some Indigenous people in Canada embrace the concept of MAiD and wish to support their families and communities through access to the same. It is well known that First Nations, Inuit, and Métis, especially in rural and remote areas, experience limitations in accessibility to health care services in Canada (National Collaborating Centre for Indigenous Health, 2019). Careful consideration needs to be given by all levels of government to policy and resources that ensure Indigenous people seeking MAiD are afforded equitable access in their home community.

Federal, provincial, and territorial governments have an obligation to take meaningful action to achieve reconciliation. To be participants in reconciliation, all levels of government must respect Indigenous peoples' right to self-determination including the right and responsibility to determine, establish and administer their own health and wellness programming. How MAiD should fit into this programming is part of this process (Standing Senate Committee on Legal and Constitutional Affairs, 2021c).

[19] See for example testimonies to the Standing Senate Committee on Legal and Constitutional Affairs from Dr. Lisa Richardson (2021b) Scott Robertson, Tyler White, Dr. Thomas Fung, François Paulette, Suzanne Stewart, Dr. Janet Smylie (2021c); Neil Belanger and Dr. Cornelia Wieman (2020d).

2.0 PANEL SCOPE AND SUMMARY OF ISSUES RAISED ABOUT MAiD AND MENTAL DISORDER

2.1 Panel Scope

Developments in law, jurisprudence, and clinical practice of MAiD have created a confusing landscape concerning MAiD and mental disorders. For example, while Bill C-7 contained an exclusion clause for mental illness, the Government of Canada recognized that persons affected by both mental and physical illness had been and would continue to be entitled to make requests for MAiD (Department of Justice, 2020a, 2020b). Clinically speaking, it is possible that for some of these requesters, their mental disorder may be the primary motivating reason for MAiD but they happen to have another physical condition that makes them eligible. And, as already mentioned, these requesters already fall under existing safeguards, protocols and guidance. Proposals for new measures for persons with MD-SUMC must consider who has access to MAiD now, what measures apply to their requests and what issues or problems need to be resolved through additional measures.

Given that the Panel was tasked with recommending safeguards, guidance and protocols for those with mental illness, its first task was to establish to whom exactly its advice would apply. The federal government acknowledged that mental illness was an expression it could not readily define. Nonetheless, it indicated "mental illness" meant conditions primarily within the domain of psychiatry but did "not include neurocognitive or neurodevelopmental disorders, or other conditions that may affect cognitive abilities, such as dementias, autism spectrum disorders or intellectual disabilities, which may be treated by specialties other than psychiatry... or specialties outside of medicine..." (Department of Justice, 2020b).

To more clearly identify which conditions fell within the Panel's mandate, the Panel compared the description of mental illness above with the federal government's stated rationale for its exclusion clause, namely that:

- there is disagreement among experts concerning if/when a mental illness can be considered irremediable;

- capacity assessments are more difficult to conduct, given that symptoms of mental illnesses can affect a person's ability to understand and/or appreciate the nature and consequences of treatment decisions;
- the trajectory of mental illnesses is generally harder to predict than those of physical diseases; and
- a desire to die is a symptom of some mental illnesses (Department of Justice, 2020b).

There are conditions that are not primarily within the domain of psychiatry, such as chronic pain conditions, that are not excluded but raise some or all of the concerns above. Conversely, there are conditions that fall within the domain of psychiatry for which MAiD has already been accessed in Canada (for example, conversion disorder (Alberta Court of Appeal, 2016) and anorexia nervosa[20]) where the above concerns were either not raised or were considered surmountable—at least in those cases in which it was accessed.

The Panel concluded that the expression 'mental illness' is an imprecise shortcut that does not capture all situations in which the concerns enumerated above arise.

For example, difficulties predicting an individual's course of illness may exist for many diagnoses (e.g., Crohn's disease, epilepsy). Decisional capacity may be impaired as a result of several conditions or their treatments such as systemic lupus erythematosus, neurocognitive disorder due to Parkinson's disease (David & Lishman, 2009, pp. 515–518; pp. 762–764), and intellectual disability (Kaplan et al., 2009, pp. 458–453). Risk of completed suicide is elevated amongst those in the first six months of a fatal cancer diagnosis compared to the general population (Du et al., 2020; Henson, 2019). Conversely, capable persons with mental disorders are entitled to make all healthcare decisions, including high-stakes decisions that may lead to their deaths such as declining or discontinuing or refusing life-saving medically necessary treatment or surgical interventions. Furthermore, most mental disorders are not associated with suicidality (American Psychiatric Association, 2022). In other words, the concerns raised by the federal government do not apply *only* to people with 'mental illness' nor to *all* people with 'mental illness'. At the same time, the concerns raised above are serious and ought to be given careful consideration *regardless of the person's diagnosis.*

While the Panel acknowledges that its mandate refers only to mental illness, the Panel believes that its recommendations for safeguards, protocols and guidance, should apply to all clinical situations in which the specific concerns identified by the federal government arise—incurability, irreversibility, capacity, suicidality, and/or the impact of structural vulnerabilities—regardless of the requester's diagnoses.

[20] See Dr. Derryck Smith's testimony to the Standing Senate Committee on Legal and Constitutional Affairs (2021c).

Recommendations

for safeguards, protocols and guidance, should apply to all clinical situations in which the specific concerns identified by the federal government arise—incurability, irreversibility, capacity, suicidality, and/or the impact of structural vulnerabilities—regardless of the requester's diagnoses.

This is consistent with the existing legal frameworks in Canada and Québec which, prior to the mental illness exclusion clause, made no mention of diagnosis of a particular condition in their eligibility criteria (Parliament of Canada, 2016; Government of Québec, 2015). It is also consistent with the *Truchon* decision which emphasized that a person who requests MAiD must be assessed in light of the totality of their clinical circumstances and on a case-by-case basis rather than on the basis of group membership (QCSC, 2019, para 466). Finally, the Panel's approach is consistent with existing standards in psychiatric practice in which diagnosis is not a guarantor of decisional incapacity, suicidality or prognosis.

2.2 Why Does MAiD MD-SUMC Require Special Attention?

Since the adoption of Bill C-7, the Canadian legislative framework for MAiD has based eligibility for MAiD on having a "grievous and irremediable medical condition." This expression is defined as having a serious and incurable illness, disease or disability; being in an advanced state of irreversible decline in capability; and, experiencing enduring physical or psychological suffering that is intolerable to the requester, caused either by the disease or the decline in capability, and that cannot be relieved under conditions that the person considers acceptable.

As noted in the Panel's Terms of Reference (Appendix A), the application of some of these terms to mental disorders is contested. The issues of suicidality and suicide prevention in the context of MAiD for mental illness are also raised in the Terms of Reference and are discussed below. Even though it was not specifically highlighted in the Terms of Reference, the significant influence of social determinants of health on the precipitation, perpetuation and exacerbation of mental disorders is a concern to many (Centre for Addiction and Mental Health, 2020, 2017; Canadian Mental Health Association, 2017). These issues are explored below.

INCURABILITY AND IRREVERSIBILITY

The terms used in the statutory definition of grievous and irremediable medical condition, particularly "incurability" and "irreversibility" denote certainty about the future. The desire for certainty is understandable given the finality of MAiD.

While the psychiatric research literature indicates significant chronicity for some patients (Verduijn et al., 2017; Solomon et al., 2010; Judd et al., 2002; Judd et al., 2005; Zanarini et al., 2010), as well as a certain proportion of patients with severe mental illness who do not respond to empirically-supported treatments (Davidson et al., 2020; Fekadu et al., 2012), the evolution of many mental disorders, like some

other chronic conditions, is difficult to predict for a given individual. This may be due to treatment, the natural history of the condition, or to a change in life circumstances. This is particularly true when one is looking ahead many years or decades.

One possible conclusion of this realization is that MAiD ought not to be allowed when natural death is not reasonably foreseeable, whether for mental disorders or for any condition when predictability is limited. Indeed, this has been a central point of disagreement in the debate about MAiD MD-SUMC, particularly amongst psychiatrists, with some saying incurability and irreversibility cannot be established and others saying that it can (Gaind, 2020b; van Veen, Ruissen & Widdershoven, 2020). How can these seemingly contradictory claims be reconciled?

In medicine, incurable is a term that is most often applicable to situations in which it is impossible, or very unlikely to be possible, to reverse the underlying pathology of the disease. Predictions about the future are based on knowledge of the continued presence of or worsening of a pathological process. For some conditions, the diagnosis alone can provide accurate information about the future course of the underlying pathology. In others, a person's response to treatment provides the information needed to make predictions about the evolution of the pathological process. Similarly, decline in function can be said to be irreversible when there is some known underlying damage to organs and tissues that cannot be changed by treatment, even if treatment can help the person to feel better. Whether about incurability or irreversibility, these kinds of predictions can be made because the underlying pathology, the impact of treatment on it, and the future course are well known.

Conflicting views expressed by psychiatrists and researchers about "incurability" and "irreversibility" reflect differing interpretations of these terms. Some may be interpreting the terms as they apply to terminal conditions; others may be interpreting them as they apply to chronic diseases. Because underlying pathology is unknown for the vast majority of mental disorders, incurable and irreversible are difficult terms to apply and are not commonly used in clinical practice when speaking about mental disorders. There is limited knowledge about the long-term prognosis for many conditions, and it is difficult, if not impossible, for clinicians to make accurate predictions about the future for an individual patient. The evolution of an individual's mental disorder cannot be predicted as it can for certain types of cancers. However, evaluating a mental disorder's treatment responsiveness on the basis of past treatment attempts can be done as it is for some other types of chronic diseases such as chronic pain conditions. This is exactly what psychiatrists do when, for example, they are asked to complete eligibility forms for long-term disability which require that the person's state will persist over time. The insurance system is asking for a statement about the future but understands this is being done only on the basis of knowledge about the past.

In terms of MAiD eligibility, having to establish incurability and irreversibility on the basis of the evolution and response to past interventions is necessary—and accepted—for other conditions such as chronic pain.[21] This is also the approach used and proposed by psychiatrists in the Netherlands and Belgium—where assisted dying for mental disorders is permitted—when they assess requests[22] (van Veen et al., 2022a, 2022b). In addition, there have been cases considered by Canadian courts to satisfy MAiD eligibility requirements in which "incurability" and "irreversibility" were established in this manner (British Columbia Supreme Court, 2016; Standing Senate Committee on Legal and Constitutional Affairs, 2021c; Alberta Court of Appeal, 2016)[23] (**see recommendations 2 and 3**).

Section 241.2(3)(a) of the *Criminal Code* also requires that before providing MAiD, a practitioner must *be of the opinion* that a person meets the eligibility criteria. Giving an opinion as a health care practitioner requires knowledge, skill and experience as specified by training bodies and regulatory authorities. Assessing incurability and irreversibility must be done in accordance with established norms of professional practice. What it means to "be of the opinion" regarding MAiD eligibility will be discussed in the recommendations section.

CAPACITY

A patient must consent to any proposed medical intervention including MAiD (CMPA, 2021a). Consent must be provided by a capable person.

All adults—including those with mental disorders—are presumed to have decision-making capacity to provide informed consent or refusal (CMPA, 2021b). However, this presumption may be displaced if it can be shown that there are reasonable grounds to conclude that a given person lacks capacity in relation to a particular decision (CMPA, 2021b). In such situations, a person's capacity to decide about a given intervention must be assessed.

What it means to have capacity to make healthcare decisions is defined at the provincial level. In certain provinces it is defined in provincial legislation (e.g., Ontario), in others (e.g., Québec), regulatory guidance provides criteria to define capacity. In practice, clinicians assess capacity by determining if a person is able to do what the definition

[21] This was conveyed to the Panel through feedback from assessors and providers with experience in Track 2 cases.

[22] The Dutch Euthanasia Centre of Expertise, "Expertisecentrum Euthanasie," which plays a prominent role in euthanasia and assisted suicide (EAS) for persons with mental disorders (they provided EAS to 84% of all Dutch mental disorder cases in 2018), conducted a study of requests for persons with psychiatric disorders made through the centre. Taking into consideration 1553 unique requests made over a seven year period, Kammeraat & Kölling found that 9.5% (149 individuals) were accepted. The most common reason for rejection of a request was the presence of other reasonable treatment options (2020, p. 95).

[23] The cases of *H.H. and E.F.* occurred prior to Bill C-14 therefore the criterion "advanced state of irreversible decline in capability" was not being assessed.

requires. For example, in Ontario, capacity is defined in the *Healthcare Consent Act* as being "able to understand the information that is relevant to making a decision…" and "able to appreciate the reasonably foreseeable consequences of a decision or lack of decision" (Government of Ontario 1996, 2017, c. 25, Sched. 5, s. 56). Clinicians assess capacity in a clinical interview, asking patients questions to ascertain if they are able to understand and appreciate the relevant information.

In its analysis of Bill C-7's compliance with the *Charter*, the federal government expressed concerns about assessment of capacity for MAiD requesters who suffer from mental illness as a SUMC, namely that it is difficult and subject to a high degree of error (Department of Justice, 2020a).

Assessing capacity can be difficult, particularly in situations in which symptoms of a person's condition, or their life experiences could subtly influence their abilities to understand and appreciate the decision they are to make. For example, someone abused in childhood and who struggles with feelings of worthlessness and self-loathing may not be able to appreciate that death is a harm if they do not believe they have any value as a human being (Muran & Motta, 1993). Deciding whether this influence affects the person's ability to appreciate consequences such that they cannot make a capable decision about MAiD can be a difficult judgment for assessors to make. This judgment can be equally challenging for other high-stakes situations such as whether to withdraw lifesaving treatment and accepting or rejecting lifesaving or burdensome treatments. Capacity assessment can also be difficult in current MAiD practice when a person suffers from coexisting mental and physical illnesses. Imagine the same person mentioned above who requests MAiD in the face of a serious medical condition because they do not believe their life is worth society's resources.

In other areas of practice, difficulties in assessing capacity are not resolved by refusing to permit access to the intervention to all persons or a subgroup of persons. When the assessment is so difficult or uncertain that the clinicians involved cannot establish that a person is capable of giving informed consent, the intervention is not provided. Similarly, the assessors must be of the opinion the person is capable of making decisions about MAiD and if the assessors cannot form this opinion, then MAiD cannot to be provided.

SUICIDALITY

Parliament, in legalizing MAiD, affirmed that, in certain cases, a desire to bring about one's death is rational, understandable, and can be assisted without violating the *Criminal Code*. The set of cases where this applies are described by the eligibility criteria. However, in considering MAiD requests for persons who have mental

disorders, it must be recognized that thoughts, plans and actions to bring about one's death may also be a symptom of the very condition for which MAiD is being requested.

Of the 157 mental disorders in the DSM-5, four main diagnoses include suicidality as a potential symptom[24] of the disorder. Psychiatric diagnoses are syndromes meaning they are defined by lists of features, not all of which may be present in an individual case. This means that even if a person has a diagnosis for which suicidality is a symptom, the individual may not have that symptom (American Psychiatric Association, 2022). Furthermore, the vast majority of people with mental disorders, including these diagnoses, do not die by suicide. That said, there is a strong association between completed suicide and the presence of a mental disorder (Arsenault-Lapierre, Kim & Turecki, 2004; Bertolote & Fleischmann, 2002).

In the suicide literature, there is some variability as to the mental disorders most frequently associated with completed suicide. At an international level, these tend to be mood disorders, substance use disorders, and personality disorders (Arsenault-Lapierre, Kim & Turecki, 2004; Bertolote & Fleischmann, 2002).

In the Netherlands the practice of euthanasia and assisted suicide (EAS)[25] was decriminalized in 2002. No distinction is drawn between mental and physical disorders. The psychiatric diagnostic categories most associated with EAS are mood disorders. Trauma and stress-related disorders, schizophrenia and other psychotic disorders, neurodevelopment disorders, and personality disorders are also found amongst the most common primary psychiatric diagnoses associated with EAS. Comorbidity, meaning that a requester has more than one mental disorder is the rule rather than the exception with majority of requesters having two or more mental disorders (Kammeraat & Kölling, 2020; Kim, De Vries & Peteet, 2016; van Veen et al., 2018).

In Belgium where the practice of euthanasia[26] for mental disorders was decriminalized in 2002, a similar pattern has emerged with mood disorders, particularly depressive disorders (Dierickx et al., 2017) and personality disorders (whether alone or comorbid with other psychiatric problems) being among the most common diagnoses associated with EAS requests by persons with mental disorders (Thienpont et al., 2015; Hermans, 2020).

[24] These are: major depressive disorder, bipolar disorder, schizoaffective disorder, borderline personality disorder. Some non-psychiatric medical problems, side effects of medical treatments, and use of certain substances may also induce changes in mood leading in some cases to suicidality.

[25] This terminology is commonly used in the Benelux and other international regimes. "Euthanasia" refers to what is known in Canada as clinician-administered MAiD and "assisted suicide" refers to what is known in Canada as self-administered MAiD (using a practitioner-prescribed substance).

[26] Although the Belgian law concerns only euthanasia, assisted suicide is also permitted.

It is important to note that knowledge of population-level risk factors, such as age, gender, the presence of a mental disorder, and type of diagnosis, does not translate to accurate predictions about individual suicides. The fact that an individual fits a risk profile does not necessarily help to accurately predict that individual's risk of completed suicide. Conversely, if a person expresses suicidality but does not have a diagnosis associated with suicide, or does not have a diagnosis at all, this does not reassure that the person is not at risk of completed suicide (Large et al., 2016; Woodford et al., 2019; Schafer et al., 2021).

The Dutch Euthanasia Centre of Expertise, "Expertisecentrum Euthanasie," which plays a prominent role in EAS for persons with mental disorders (they provided EAS to 84% of cases in 2018), conducted a study of requests for persons with psychiatric disorders made through the centre. Taking into consideration 1,553 unique requests made over a seven year period, the authors found that 3.9% (59 individuals) completed suicide during or after the euthanasia assessment process, a process which lasted on average ten months (Kammeraat & Kölling, 2020, pp. 106–108).

Given these associations and difficulties in individual predictions, how should we understand requests for MAiD by a person with a mental illness? Even before the era of MAiD, clinicians were confronted with situations in which patients made decisions that would certainly or probably lead to their deaths, whether these were informed refusals of life-sustaining or life-saving treatments, non-adherence to life-sustaining treatments, or repeated engagement in high-risk behaviours, to name a few examples.

In these high-stakes clinical situations the clinician must undertake three actions simultaneously: 1. consider a person's capacity to give informed consent to make such decisions; 2. consider whether or not suicide prevention interventions should be activated, including against the will of the person if necessary;[27] and, 3. consider what other types of interventions could be helpful to the person including non-intervention. Even though decision-making capacity is presumed for all healthcare decisions, if clinicians have reasons to doubt capacity (and a decision that will lead to death often raises doubts about capacity) then it must be assessed in light of the decision being made. Invoking measures of suicide prevention, particularly involuntary ones, tends to occur when a person has a history of suicide attempts, a history of a mental disorder, and/or is in a state of crisis or other reversible circumstance. The third action, offering

[27] BC: *Mental Health Act*, RSBC 1996, c 288; Alberta: *Mental Health Act*, RSA 2000, c M-13; Saskatchewan: *Mental Health Services Act*, SS 1984–85-86, c M-13.1; Manitoba: *Mental Health Act*, CCSM c M110; Ontario: *Mental Health Act*, RSO 1990, c M.7; Quebec: *Mental Patients Protection Act*, RSQ, c P-41; Nova Scotia: *Involuntary Psychiatric Treatment Act*, SNS 2005, c. 42, s. 1; New Brunswick: *Mental Health Act*, RSNB 1973, c M-10; Prince Edward Island: *Mental Health Act*, RSPEI 1988, c M-6.1; Newfoundland and Labrador: *Mental Health Care and Treatment Act*, SNL 2006, c M-9.1; Yukon: *Mental Health Act*, RSY 2002, c 150; Northwest Territories: *Mental Health Act*, RSNWT 1988, c M-10; Nunavut: *Mental Health Act*, RSNWT (Nu) 1988, c M-10.

and negotiating therapeutic options, is always part of the care plan and continues in parallel whether or not voluntary or involuntary suicide prevention measures are in play.

Clinicians do not prevent people (including those with mental disorders) from making life-ending decisions in all cases. In situations where there is no acute crisis and the person is capable to make the decision, clinicians encourage preservation of life through all therapeutic mechanisms available, but do not go so far as to prevent a person from making a potentially fatal decision in every situation. This approach is consistent with existing legal and ethical norms concerning informed consent, decision-making capacity, and involuntary hospitalization for mental disorders.

In addition to non-MAiD situations of high-stakes decision-making, people with mental disorders and coexisting physical disorders are potentially eligible for MAiD at present. Individualized suicide assessments that take into consideration the above elements are *already* part of current MAiD assessment practices as are suicide prevention efforts when these are warranted.[28]

STRUCTURAL VULNERABILITY, MENTAL DISORDER[29] AND MAiD

Structural vulnerability refers to the impacts of the interaction of demographic attributes (sex, gender, socioeconomic status, race/ethnicity, sexuality, institutional location), with assumed or attributed statuses related to one's position in social, cultural, and political hierarchies (including normality, credibility, and whether one deserves to receive care). In the healthcare context, structural vulnerability requires reflection on these forces that "constrain decision-making, frame choices, and limit life options" and the manner that these in turn impact health outcomes (Quesada, Hart & Bourgois, 2011; Bourgois et al., 2017).

Even preceding the original MAiD law, the role of structural vulnerabilities in motivating MAiD requests was questioned repeatedly in public and academic debates (Shariff, 2011; Special Joint Committee on Physician-Assisted Dying, 2016; Vulnerable Persons Standard, 2017). For example, some expressed concerns that people who are economically disadvantaged would not have access to palliative care and would disproportionately seek MAiD as a result. While a thorough exploration of the ways in which vulnerabilities, and the interaction of these vulnerabilities, can cause and perpetuate suffering sufficient to lead to MAiD requests is beyond the scope of this

[28] This was conveyed to the Panel through feedback from assessors and providers with experience in Track 2 cases.

[29] There is an intersection between mental disorder and disability. In some cases, a mental disorder is sufficiently impairing that it constitutes a disability. Others consider all mental disorders to be disabilities (World Health Organization, 2019, p. xxv). Regardless of which term is applied, structural vulnerabilities affect various social groups including those with mental disorders.

report, the Panel will summarize some of the key points made by people with lived experience of mental disorders and organizations that advocate on their behalf about structural vulnerability, mental disorder and MAiD.

During the legislative process leading to the passage of Bill C-7,[30] divergent viewpoints were expressed about MAiD MD-SUMC (Standing Senate Committee on Legal and Constitutional Affairs 2020a, 2021a; Estrada, 2021). The basic tension underlying these divergences lies in the role structural vulnerabilities might play in inciting people to request MAiD MD-SUMC versus the right of people with mental disorders—persons already subject to structural vulnerabilities such as perceptions of decisional incapacity—to make health-related decisions.

Persons with mental disorders are more likely to be in situations of structural vulnerability than the general population, particularly those most severely affected. For example, they are more likely to be viewed as violent, even though they are at least equally likely to be the victims of violence (de Vries et al., 2019; Sariaslan et al., 2020; Appelbaum, 2020). The impact of this and other negative perceptions may lead to difficult social circumstances such as unstable housing and lack of employment opportunities (Canadian Mental Health Association, 2022). In addition, they often have a limited social network of people who can provide material support and advocacy when needed (Koenders et al., 2017; Richter & Hoffman, 2019). These kinds of vulnerabilities may directly cause a person's suffering.

Structural vulnerabilities may also contribute to suffering indirectly by leading to a lack of access to care. This can occur through a variety of mechanisms. For example, mental health care can be provider- rather than patient-centred in assuming that people can attend appointments during the day and find transportation and childcare in order to participate in clinical programs. Second, the care that is offered may focus narrowly on medical treatment rather than on allied healthcare and social services needed to improve quality of life and address basic needs. When these additional services are considered, they may not be covered by provincial health care programs, or there may be long wait times to access them. Finally, past negative or even traumatic experiences receiving care, particularly coercion, may contribute to refusing further care and even seeking MAiD if suffering persists. Alternatively, limited access to quality care may lead people to request MAiD in order to gain access to those services[31].

[30] This includes the hearings of the House of Commons Standing Committee on Justice and Human Rights, the Standing Senate Committee on Legal and Constitutional Affairs, and during the round tables conducted by the federal government in January and February 2020.

[31] This concern was communicated by Panel member Leora Simon who received these comments in her work with people with lived experience.

At the same time, people with lived experience worry that if they do request MAiD, their requests may not be taken seriously. Persons with mental disorders may be assumed, incorrectly, to be incapable of consenting to receive MAiD. Their suffering may not be visible and the severity or unbearableness of it may be underestimated by assessors. A request may be taken as evidence the person is suicidal and even lead to coercive measures such as involuntary hospitalization. Or, requests might be dismissed as a sign of manipulation or provocation, especially when associated with certain diagnoses such as borderline personality disorder or in the context of family or other social difficulties.[32] In Canada, the fact that people with mental disorders can be subject to laws allowing coercive treatment and hospitalization in some cases underscores the importance of recognizing their right to capable decision-making on a par with all other Canadians.

That MAiD requests may mask profound unmet needs or conversely, that such requests may not be received with the seriousness they deserve, has been raised with respect to several historically marginalized populations (e.g., racialized groups including Indigenous peoples, persons living with disabilities, and sexual orientation and gender minorities). The theme uniting these concerns is wanting to be treated equitably compared to others both with respect to access to resources, and with respect to individual rights to make autonomous decisions.

[32] Ibid

3.0 RECOMMENDATIONS

The Panel acknowledges that its mandate is specific to MAiD for persons with mental illness. However, as explained in the first section of the report, the concerns raised about MAiD for persons with mental disorders may also arise for other conditions. The Panel's nineteen recommendations, particularly recommendations two through thirteen, concerning the clinical practice of MAiD, are considered to be applicable to any conditions where there is uncertainty about incurability, irreversibility, capacity, suicidality, and the impact of structural vulnerabilities.

Numerous commentators have raised questions about clarity and meaning of the language found in the *Criminal Code* for MAiD. For example, in the original MAiD law, the meaning of RFND generated uncertainty amongst practitioners (Downie & Chandler, 2018; FMRAC, 2016). The CMPA and FMRAC have indicated to the Panel that clarity of language, particularly with respect to the eligibility criteria and the safeguards is essential. This is not only a matter of protecting assessors and providers from criminal sanction and regulatory discipline. It is also to avoid the unintended consequence of limiting MAiD access because practitioners are fearful of professional involvement in the absence of clear practice parameters. The CMPA expressed its views to the Panel in the following terms:

> The CMPA cannot overstate the importance of having operational clarity on eligibility and safeguard requirements as well as clear guidance from regulatory authorities and medical societies with respect to supporting these patients and assessing their eligibility for MAiD. Uncertainty with respect to the interpretation or application of certain provisions of the legislation, or ambiguity in regulatory guidance, may negatively affect access to MAiD (2021c).

For its part, FMRAC told the Panel that:

> It is imperative that the language in the *Criminal Code* pertaining to the provision of MAiD for a mental illness…be as clear as possible…The MRAs [medical regulatory authorities] are concerned that, failing the required level of clarity, they may be expected to interpret the *Criminal Code* for the profession. This would not be appropriate (2022).

The terms contained within the *Criminal Code* (most notably, incurable and irreversible) must be applied to actual requesters by actual practitioners. The message from FMRAC raises an important question. If there is uncertainty about the meaning of certain terms, who will help practitioners understand their meaning and application in clinical practice?[33]

Since the *Criminal Code* does not define certain terms relating to MAiD eligibility, their legal interpretation is a matter for the courts to resolve, but in the absence of a case in which the terms must be interpreted, such interpretations will not be forthcoming.[34] The provincial/territorial Attorneys General and/or Directors of Public Prosecution can issue guidelines (which could provide interpretive guidance) for the exercise of prosecutorial discretion with respect to enforcement of the *Criminal Code* but they have not done so with respect to these terms. Provincial and territorial regulatory authorities have been delegated responsibility to establish professional standards and regulate clinical practice, but they too have not offered up interpretations of certain key terms used in Canada's MAiD legislation.

The Panel is of the opinion that it is necessary that practitioners be given some direction about how to operationalize these terms clinically for MAiD MD-SUMC. In the absence of definitive legal interpretations, the Panel seeks to propose meanings of some of the key terms in the eligibility criteria and safeguards. In doing so, we have considered proposals made by other Canadian organizations about the meanings of these terms (see Appendix E).

The first thirteen recommendations focus on the meaning and applicability of the eligibility criteria and safeguards in clinical practice and attempt to respond to the concerns laid out in Section two of this report. The remaining six recommendations concern implementation. As MAiD is an area of concurrent jurisdiction, some recommendations will require concerted action by both federal and provincial/territorial levels of governments. Others require collaboration by actors such as regulators and professional associations.

The Panel believes that its recommendations can be fulfilled without adding new legislative safeguards to the *Criminal Code*. Instead, the Panel found that the existing MAiD eligibility criteria and safeguards buttressed by existing laws, standards, and practices in related areas of healthcare can provide an adequate structure for MAiD MD-SUMC so long as those are interpreted appropriately to take into consideration the specificity of mental disorders.

[33] In an article published in the Toronto Star on March 27, 2022, Dr. Stefanie Green, a MAiD provider, describes the challenges of trying to make clinical decisions about MAiD eligibility when key terms in the criteria are not interpreted for clinicians.

[34] In determining the legal meaning of these terms, a court may consider Parliamentary proceedings as an interpretative aide, though any such statements or documents are not binding.

The Panel believes

that its recommendations can be fulfilled without adding new legislative safeguards to the Criminal Code. Instead, the Panel found that the existing MAiD eligibility criteria and safeguards buttressed by existing laws, standards, and practices in related areas of healthcare can provide an adequate structure for MAiD MD-SUMC so long as those are interpreted appropriately to take into consideration the specificity of mental disorders.

In the Panel's view, adequate funding of health and social resources is essential and other groups have made specific proposals in this regard (Association des médecins psychiatres du Québec (AMPQ), 2020; Expert Advisory Group on Medical Assistance in Dying, 2020; Halifax Group, 2020). These resources should span from access to appropriate medical care in chronic physical illness, to bolstering availability of psychosocial and somatic interventions in chronic mental illness, to programs that strive to combat structural vulnerabilities, and those dedicated to suicide prevention. As the CMPA stated in its communication with the Panel: "It is especially important that resources be available in all regions to allow physicians to meaningfully apply the additional safeguards where death is not reasonably foreseeable (e.g., offering support services and ensuring the patient has given serious consideration to these services)" (2021c).

Set out below are the Panel's recommendations referencing safeguards, protocols and guidance relevant to the practice of MAiD MD-SUMC. In developing these recommendations, the Panel considered the existing legislative framework, safeguards in international jurisdictions, and those proposed by Canadian professional associations and groups (see Appendices D and E). The recommendations are interdependent and reflect an overall approach to structuring the practice of MAiD MD-SUMC. However, they are a starting point and will require further elaboration by regulators, professional associations and institutions to provide the details necessary for practical application.

A note to the reader: in what follows, the Panel provides a small number of clinical case vignettes. These are fictional cases but are inspired by real ones. The cases are not intended to provide examples of requesters who are eligible or ineligible. They are provided to illustrate certain clinical concepts under discussion that may be unfamiliar to some readers.

3.1 Development of MAiD Practice Standards

Many of the potential challenges involving MAiD for requesters with mental disorders should be addressed through rigorous assessment procedures. Given that all practitioners are governed by their local regulatory authorities, and regulators guide clinical practice in the public interest, these bodies are ideally positioned to develop practice standards for MAiD with patient safety in mind.

RECOMMENDATION 1: DEVELOPMENT OF MAiD PRACTICE STANDARDS

The federal, provincial and territorial governments should facilitate the collaboration of physician and nurse regulatory bodies in the development of Standards of Practice for physicians and nurse practitioners for the assessment of MAiD requests in situations that raise questions about incurability, irreversibility, capacity, suicidality, and the impact of structural vulnerabilities. These standards should elaborate upon the subject matter of recommendations 2–13.

In Québec, the Collège des Médecins du Québec (CMQ) together with the Ordre des Infirmiers et Infirmières du Québec have developed comprehensive practice standards for MAiD (CMQ, 2018). Canadian medical regulators have also collaborated on a brief uniform MAiD standard (FMRAC, 2015) which could be used as a springboard to a more detailed practice standard. The provincial and territorial regulators should work together on such an initiative as this would assist in creating a harmonized MAiD system across Canada, something that is desired by practitioners, requesters, governments and regulators themselves (CMQ, 2021; Canadian Psychiatric Association (CPA), 2022; FMRAC, 2022).

3.2 Interpreting 'Grievous and Irremediable Medical Condition'

The interpretation and application of the eligibility criterion 'grievous and irremediable medical condition' has generated considerable debate (Gaind, 2020a, 2020b; Bahji & Delva, 2021; Dembo, Schuklenk & Reggler, 2018; Standing Senate Committee on Legal and Constitutional Affairs, 2021b, 2020b, 2020c). Some practitioners are concerned particularly about how to apply the term 'irremediable' in the context of mental disorder (CPA, 2021).

The expression 'grievous and irremediable medical condition' is defined in the *Criminal Code* by three components: an incurable illness, disease or disability; an advanced state of irreversible decline in capability; and, enduring and intolerable suffering. Because the expression 'grievous and irremediable medical condition' is already defined in this way in the *Criminal Code*, the Panel's approach is to interpret each of the three components of the statutory definition. The Panel explored these components in depth and has formulated recommendations (2–4) aimed at guiding assessors in the application of these elements.

At the same time, the Panel recognizes the interdependence of the three elements, particularly in the practical context of clinical assessment. Together the three elements paint a portrait of the kind of clinical circumstances for which MAiD may be an option.

A. is a 63-year-old single man who was diagnosed with bipolar disorder at age 35. His mother is 88 years old and lives independently. His father died 10 years ago of a heart attack. He has no siblings. Mr. A. was a secondary school teacher but was unable to maintain his employment due to the frequency and duration of his absences from work resulting from his disorder. He has been hospitalized 15 times since diagnosis, and involuntarily on seven occasions. He was considered incapable of consenting to treatment during three hospitalizations. He has had ongoing care with a psychiatrist since his first hospitalization at age 35. He has tried multiple different medications, combinations of medications, electroconvulsive therapy (ECT) and transcranial magnetic stimulation (TMS). He has also had extensive psychological and social service supports. His depressive episodes have grown longer and more severe as he has aged. He has never attempted suicide.

In the context of MAiD MD-SUMC, a grievous and irremediable medical condition exists in circumstances where a person has a longstanding condition[35,36] leading to functional decline and for which they have not found relief from suffering despite an extensive history of attempts with different types of interventions and supports.

[35] In a survey of its members, the AMPQ found that nearly half believed a person should be affected for at least ten years before they could be considered for eligibility (2020, p.28).

[36] In its retrospective chart review of a sample of requesters of EAS for mental disorders, the Expertisecentrum Euthanasie found that more than 60% of requesters had ten years or more of treatment for their conditions (Kaameraat & Kölling, 2020, p.60).

In the context

of MAiD MD-SUMC, a grievous and irremediable medical condition exists in circumstances where a person has a longstanding condition leading to functional decline and for which they have not found relief from suffering despite an extensive history of attempts with different types of interventions and supports.

ESTABLISHING INCURABILITY AND IRREVERSIBILITY

RECOMMENDATION 2: ESTABLISHING INCURABILITY

MAiD assessors should establish incurability with reference to treatment attempts made up to that point, outcomes of those treatments, and severity and duration of illness, disease or disability.

It is not possible to provide fixed rules for how many treatment attempts, how many kinds of treatments, and over what period of time as this will vary according to the nature and severity of medical conditions the person has and their overall health status. This must be assessed on a case-by-case basis.

The Panel is of the view that the requester and assessors must come to a shared understanding that the person has a serious and incurable illness, disease or disability. As with many chronic conditions, the incurability of a mental disorder cannot be established in the absence of multiple attempts at interventions with therapeutic aims.

RECOMMENDATION 3: ESTABLISHING IRREVERSIBILITY

MAiD assessors should establish irreversibility with reference to interventions tried that are designed to improve function, including: recognized rehabilitative and supportive measures that have been tried up to that point, outcomes of those interventions, and the duration of decline.

It is not possible to provide fixed rules for how many attempts at interventions, how many types of interventions, and over how much time, as this will vary according to a requester's baseline function as well as life goals. Therefore, this must be assessed on a case-by-case basis.

The Panel is of the view that the requester and assessors must come to a shared understanding that the person is in an advanced state of irreversible decline in capability.

There are a variety of interventions that may be effective in relieving suffering related to a mental disorder (Stergiopoulos et al., 2019). Beyond what is recognized in established practice guidelines and is accepted as being the standard of care, adequate social supports including housing and income support should have been offered. Consideration should be given to whether the requester has received care in a culturally safe setting (Curtis et al., 2019) with access to trauma-informed and culturally-appropriate interventions (First Nations Health Authority & Island Health, 2020). Where appropriate, interventions focused on suicidality, harm-reduction and recovery should have been attempted (Mental Health Commission of Canada, 2021; Nicolini, Gastmans & Kim, 2022; Miler et al., 2021).

In the context of mental disorders, capability refers to a person's functioning (social, occupational or other important area). Function should be understood from a recovery perspective. A recovery perspective focuses on quality of life from the person's point of view. "An analysis of numerous accounts by consumers of mental health services … suggests that the key internal conditions in this process are hope, healing, empowerment and connection." The external conditions that define recovery are human rights, "positive culture of healing" and recovery-oriented services (Jacobson & Greenley, 2001). Advanced decline means the worsening in function is severe.

Incurability and irreversibility do not require that a person has attempted up to that point in time, every potential option for intervention irrespective of the potential harms, nor that a person must attempt interventions that exist but that are inaccessible. The requester and assessors must balance potential benefits and burdens going forward of any remaining interventions.

In certain countries permitting assisted dying for those with mental disorders, practitioners have developed this type of approach. For example, in the Netherlands, the assessors must be convinced that "the patient is suffering unbearably without any prospect of improvement," and "there are no reasonable alternatives to relieve suffering" (Government of the Netherlands, 2002, art. 2). Similarly, in Belgium, the assessors must be convinced that "the patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated" (Government of Belgium, 2002, ch. 2, s. 3). The Dutch Psychiatric Association (NVvP) has developed detailed practice guidelines to help apply these criteria to assessments of persons with mental disorders. The NVvP considers that there is a possibility of a 'reasonable treatment perspective' for a person with a mental disorder if:

- there is a prospect of improvement by adequate treatment
- within a manageable period of time
- with a reasonable ratio between the expected results and the burden of the treatment for the patient (NVvP, 2018, p.33).

In Belgium where euthanasia is permitted for persons with mental disorders, the Flemish Psychiatric Association (VVP) endorses the above approach (VVP, 2017, p.16).

Capable persons are entitled to refuse treatment. In the case of *Starson v. Swayze* the SCC noted that, "the right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy. This right is equally important in the context of treatment for mental illness" (SCC, 2003, para 75). However, a requester's reasons for refusing certain interventions should be explored. For example, a requester may have had severe treatment side effects, traumatic experiences receiving care or may have cultural or religious beliefs that preclude certain treatments. Interventions requiring a requester to move to a distant location for a prolonged period of time may be too difficult for the person to endure. These reasons may clarify why certain interventions are not acceptable to the person. At the same time, a capable refusal of treatments with a favourable benefit/burden balance will not lead to automatic access to MAiD. In such cases, assessors may not be able to form an opinion about the incurability of the condition or the irreversibility of decline as this opinion relies upon a history of multiple and multimodal treatment attempts.

This kind of balancing between what is available and likely to help versus what the person is able to endure will be part of the case-by-case assessment of incurability and irreversibility for other conditions (in addition to mental disorders) that raise the same concerns.

UNDERSTANDING ENDURING AND INTOLERABLE SUFFERING

RECOMMENDATION 4: UNDERSTANDING ENDURING AND INTOLERABLE SUFFERING

MAiD assessors should come to an understanding with the requester that the illness, disease or disability or functional decline causes the requester enduring and intolerable physical or psychological suffering.

The third element of the definition of grievous and irremediable medical condition refers to the suffering experienced by a MAiD requester and states: "that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable" (Parliament of Canada, 2016). Suffering is a personal experience, and this part of the definition also indicates that it is subjective.

Mental disorders are commonly understood as problems of thinking, feeling, and behaving. These problems can affect one's experiences, perceptions, and interpretations of self and others (Kaplan et al., 2009). In some cases, a mental disorder can lead a person to overestimate the immovability of suffering, to underestimate their abilities to cope with stressors connected to the suffering, or misattribute its cause. One of the core aspects of clinical work in mental health-related disciplines is to assist individuals to develop realistic interpretations of, and appropriate reactions to, their interactions with others, bodily experiences and/or memories of the past (Beck, 2005; Beck, 1995, pp. 1–12). A person's interpretations of the persistence and permanence of their suffering resulting in a request for MAiD should reflect a realistic appraisal of their situation.

B. is a 56-year-old man referred for a MAiD assessment by his family doctor for severe pain for three years, unresponsive to interventions. The patient stated, "this pain is killing me and I don't want to live like this." He said he received no help from the pain clinic. The pain clinic reported that he had attended on 4 occasions. He refused the treatment options including oral and injectable medications as well as physiotherapy. He insisted on receiving prescriptions for opiate analgesics and became verbally abusive when these were refused. According to his GP, the patient had been fired from his job three years ago for alcohol intoxication at work. He said he had back pain and had been drinking to stop the pain. He had been drinking heavily for a number of years and had assaulted his wife on several occasions while intoxicated blaming her for his problems. She separated from B. four years ago. During the assessment he says, "After I get MAiD I hope my ex-wife feels really guilty. It's her fault I will be dead."

The second part of the suffering sub-criterion is that the requester's suffering cannot be relieved under conditions they consider acceptable. Consistent with existing laws and norms concerning consent and capacity, capable persons are usually entitled to refuse interventions they do not wish to receive (Gilmour, 2017; Robertson, 2017, pp. 53–58).

3.3 Vulnerabilities: Incapacity, Structural Vulnerability, Involuntariness, and Suicidality

The recommendations in this section concern potential vulnerabilities: incapacity, structural and societal factors that lead to marginalization, involuntariness, and suicidality.

In *Truchon*, Justice Baudouin accepted the following evidence:

> The vulnerability of a person requesting medical assistance in dying must be assessed exclusively on a case-by-case basis, according to the characteristics of the person and not based on a reference group of so-called 'vulnerable persons.' Beyond the various factors of the vulnerability that physicians are able to objectify or identify, the patient's ability to understand and to consent is ultimately the decisive factor, in addition to the other legal criteria (QCSC, 2019, para 466[3]).

The Panel is of the opinion that the highest standards of assessment will be necessary to ensure that vulnerabilities of individual requesters are properly considered in MAiD requests for complex Track 2 cases, including those for mental disorder as the SUMC (**see recommendations 5, 7, 8, 10–13**).

Given that Track 2 MAiD requests require the requester to make a very high-stakes decision, capacity assessments must be rigorous, as they must be with other medical decisions with life-ending consequences. The level of abilities required to meet the capacity threshold of understanding and appreciation is decision-specific because complexity and significance of decisions varies (Gilmour, 2017). To be capable with respect to the decision to have MAiD MD-SUMC, the level of abilities needs to be proportionate to the significance of the decision and complexity of information that must be weighed (Freeland et al., 2022; Grisso & Appelbaum, 1998b, p. 23). Serial assessments of capacity may be necessary especially when mental states fluctuate. Assessors should attempt to assess consistency of MAiD requests across different mental and emotional states, including during periods of fewest symptoms (Grisso & Appelbaum, 1998a, p. 92).

COMPREHENSIVE CAPACITY ASSESSMENTS

RECOMMENDATION 5: COMPREHENSIVE CAPACITY ASSESSMENTS

MAiD assessors should undertake thorough and, where appropriate, serial assessments of a requester's decision-making capacity in accordance with clinical standards and legal criteria. These assessments should be consistent with approaches laid out in standardized capacity evaluation tools.

In order to undertake rigourous capacity assessments, assessors must be familiar with standardized, validated, capacity assessment tools such as the MacArthur Competence Test for Treatment (MacCAT-T) (Grisso & Appelbaum, 1998c). The MacCAT-T has been used to support capacity assessment in other serious medical decisions (Lapid et al., 2004; Kerrigan et al., 2014; Rahman et al, 2012). The MacCAT-T, however, does not take into account factors such as emotional state and values (Hermann et al., 2016; Charland, 2006). One group of researchers has also tried to address factors such as the values of the assessor, and has created a tool called the U-Doc (Hermann et al., 2020), which is complementary to tests like the MacCAT-T. These standardized capacity tests and others like them should be considered as possible aids to clinical assessment but do not replace clinical evaluation (Dunn et al., 2006).

In law, a person is either capable or not capable. However clinically, in the course of assessing a person's capacity, it may be apparent the person is in an intermediate situation as they have diminished capacity rather than being completely incapable. In these situations, with assistance, a person could be helped to make their own capable decisions. This is consistent with the United Nations Convention on Rights of Persons with Disabilities (CRPD), which declares that people with disabilities have legal capacity on an equal basis with others in all aspects of life (2008, Article 12). This type of 'supported decision-making approach' has already been used from time to time in MAiD assessments.[37]

Supported decision-making is a model that aims to support the autonomy and self-determination of requesters with impairments or challenges in making health care decisions on their own because of physical and/or mental illness or disability (Davidson et al, 2015). This approach includes a variety of potential types of supports. One model is the presence of a third party (i.e., in addition to the traditional model of

[37] This was conveyed to the Panel through feedback from assessors and providers with experience in Track 2 cases.

patient and health care provider) who, with the requester's consent, actively supports the requester in making and communicating a health care decision (Gooding, 2013). Through supported decision-making approaches, some people who might otherwise be considered incapable may be able to achieve the necessary understanding and appreciation of relevant information and consequences of the decision to make their own capable choice about MAiD.

Given the potential for increased vulnerability of people with diminished capacity, including the influence of others, it is important to monitor the use of supported decision-making in this context. We have proposed that details about supported decision-making procedures be captured in the federal MAiD monitoring system (**see recommendation 18**).

MEANS AVAILABLE TO RELIEVE SUFFERING

RECOMMENDATION 6: MEANS AVAILABLE TO RELIEVE SUFFERING

To ensure all requesters have access to the fullest possible range of social supports which could potentially contribute to reducing suffering, we recommend that 'community services' in Track 2 Safeguard 241.2(3.1)(g) should be interpreted as including housing and income supports as means available to relieve suffering and should be offered to MAiD requesters where appropriate.

Track 2 Safeguard 241.2(3.1)(g) states that MAiD assessors and providers must "…ensure that the person has been informed of the means available to relieve their suffering including, where appropriate, counselling services, mental health and disability support services, community services, and palliative care and has been offered consultations with relevant professionals who provide those services or that care."

Individuals living with chronic mental or physical illness, including severe, persistent mental illness, are more likely to experience structural vulnerability brought about by unstable and unsafe housing and inadequate financial means (Sareen et al., 2011; Padgett, 2020). The efficacy of housing and income supports is supported by Canadian data demonstrating improvements in quality of life and functional ability, as well as reducedlength of hospital stays and reduced arrests (O'Campo et al., 2016; Stergiopoulos et al., 2019). Other Canadian reports have, consistent with international

studies (Owusu-Addo, Renzaho, & Smith, 2018; Kangas et al., 2020; Patel & Kariel, 2021), established the benefits of basic income, finding that it can improve physical and mental health, food security, relationships, and sense of self-worth, and reduce emergency room visits (Ferdosi et al., 2020). While structural vulnerability may contribute to a person's experience of a chronic medical condition, the Panel does not believe persons in situations of structural vulnerability should be excluded systematically from access to MAiD. Rather, local MAiD coordinating services should ensure assessors are equipped to present requesters with a complete picture of any additional means available to relieve suffering and should make all reasonable efforts to ensure requesters have access to these means.

INTERPRETATION OF TRACK 2 SAFEGUARD 241.2(3.1)(h) THE PERSON HAS GIVEN SERIOUS CONSIDERATION TO THOSE MEANS

RECOMMENDATION 7: INTERPRETATION OF TRACK 2 SAFEGUARD 241.2(3.1)(h) THE PERSON HAS GIVEN SERIOUS CONSIDERATION TO THOSE MEANS

Serious consideration should be interpreted to mean genuine openness to the means available to relieve suffering and how they could make a difference in the person's life.

"Serious consideration" is only possible if a requester has been given adequate information to provide an informed consent.[38] In addition, serious consideration also includes an openness to genuinely consider the means available to relieve suffering—an ability to 'try on' different options and imagine how the means suggested might apply to the requester's life, not only the ability to hear the information and repeat back what has been discussed. This requires an awareness of how the symptoms of the mental disorder may impact the person's ability to consider options in this manner.[39]

[38] Consent to MAiD, and any healthcare intervention, must be informed, voluntary, and given by a capable person. For a discussion of what informed consent entails, see for example: **www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/communication/Informed_Consent/three_key_elements-e.html**

[39] In the case of *Starson v Swayze*, the SCC noted, "Psychiatry is not an exact science," capable but dissident interpretations of information" are to be expected…While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental 'condition' the patient must be able to recognize the possibility that he is affected by that condition" (2003, para 79).

The reason “serious consideration” seems to require something beyond the requester being capable of providing informed consent is that the requirements of capacity and informed consent are articulated elsewhere in the MAiD law. We assume the use of the phrase “serious consideration” is not mere duplication of what is already articulated elsewhere as general requirements.

P. is a 58-year-old person with OCD and more recently chronic pain following an automobile accident. They have requested MAiD primarily due to the suffering caused by obsessive-compulsive disorder (OCD) although their pain plays a role in their request. They have tried one medication to treat OCD so far, but stopped it due to side effects. They have participated in a mindfulness group therapy program. They are unwilling to try pain medications because they fear becoming addicted to them. When their psychiatrist recommended another medication to treat OCD, they were unwilling to discuss it because they had side effects from the first one they tried. They are not willing to try exposure and response prevention therapy (a non-pharmacological treatment) which has the best research behind it as a treatment of OCD because they say they know it will not work. They are not open to learning anything more about it from the assessor.

THE CONSISTENCY, DURABILITY, AND WELL-CONSIDERED NATURE OF A MAiD REQUEST

Requesters of MAiD MD-SUMC should be assessed serially, including when possible, during periods of remission or reduced symptoms, and not during periods of acute emotional distress or crisis. Because some mental disorders are associated with suicidality, both acute and chronic suicidal ideation must be considered and evaluated to best determine whether the requester's wish to end their life by MAiD represents a capable appraisal of their situation rather than a potentially treatable symptom of their mental disorder. This will include consideration of whether the desire for MAiD is based upon a sound reasoning process consistent with the person's values and beliefs, as well as the chronicity of the condition(s) and extensive treatment experience.

RECOMMENDATION 8: CONSISTENCY, DURABILITY, AND WELL-CONSIDERED NATURE OF A MAiD REQUEST

Assessors should ensure that the requester's wish for death is consistent with the person's values and beliefs, unambiguous and rationally considered during a period of stability, not during a period of crisis.

By itself, a request for MAiD by a person with a mental disorder should not be interpreted as suicidal ideation, even if suicidality is listed as one of the diagnostic criteria of the person's mental disorder. Since the majority of MAiD MD-SUMC requests will fall under Track 2 and require a minimum 90 day assessment period, the requirement of proximate harm to self in the mental health legislation of most provinces and territories to permit involuntary hospitalization (Ontario Hospital Association, 2016, p. 12; Government of Québec, 1997, art. 7; Carver, 2011) is not met by the simple fact of making a MAiD request.

If a requester for MAiD MD-SUMC has a history of or current suicidal ideation or attempts, the usual clinical approach to assessing suicidality should apply. This includes considerations of whether the person has a history of suicide attempts, current thoughts about suicide or intent and a realistic and a proximate plan (Kaplan et al., 2009). Population-derived risk factors such as gender, social isolation and substance abuse should be explored.[40] If these factors point to acute risk, suicide prevention measures

[40] Even though clinically, population-derived factors are often explored in suicide risk assessments, the predictability of completed suicide based on the presence or absence of population-derived risk factors is poor (Mulder, Newton-Howes, & Coid, 2016; Large et al., 2016).

can be mobilized as they are in usual clinical practice including involuntarily if the situation fulfills the criteria under mental health legislation. This is true both during and after an assessment for MAiD.

In *Truchon*, Justice Baudouin accepted the following evidence: "The physicians involved are able to distinguish a suicidal patient from a patient seeking medical assistance in dying. Moreover, there are important distinctions between suicide and medical assistance in dying with respect to both the characteristics of the people involved and the reasons that motivate them" (QCSC, 2019, para 466[4]).

The physicians referred to in this statement were discussing their assessments of requesters whose natural deaths were reasonably foreseeable or who were at the end of life. While it may be more straightforward to rule out suicidality at the end of life, or for persons with no history of suicidality themselves, like Truchon and Gladu, this may be more difficult in persons with chronic suicidal thinking and behaviour who request MAiD. Whether there is a distinction between MAiD and suicide is a point of debate in the clinical literature with some arguing these are two distinct phenomena (Creighton, Cerel & Battin, 2017), others arguing that they are not (Reed, 2019), and some claiming that even if they are distinct, in practice, practitioners cannot tell them apart (Nicolini et al., 2020).

C. is a 70-year-old woman with severe major depressive disorder and post-traumatic stress disorder diagnosed at age 18. She has expressed a desire to die since she was 20 years old and has made approximately 30 suicide attempts during her life, many of which were severe enough to require medical hospitalizations. She is unable to work and does not wish to have any social relationships because of her mental state. She has requested MAiD because the symptoms of her disorders have been refractory to over 35 recognized psychosocial interventions and somatic (medications and neuromodulatory) treatments and she does not want to try any more. She has no plan to attempt suicide at present.

The NVvP has reflected on this issue and writes:

> In some patients the wish to die is the result of a careful weighing process and becomes durable. When suicidality is durable and there is a chronic mental disorder, when the patient can act in proportion to his disorder (in other words can form a reasoned opinion about it) and when he also asks for help to perform his wish to die, then the difference between suicidality and a termination of life request becomes smaller and may even fade completely (NVvP, 2018, p. 36).

For the NVvP, it is possible for persons with chronic suicidal thinking and chronic mental disorders, to make a reasoned wish to die (NVvP, 2018).

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

'Be of the opinion'

Recommendations (2–5 and 8) concern the assessment of certain eligibility criteria.

Following the list of eligibility criteria for MAiD, the Criminal Code states the following:

> *241.2(3.1) Before a medical practitioner or nurse practitioner provides a person with medical assistance in dying, the medical practitioner or nurse practitioner must (a) be of the opinion that the person meets all of the legal criteria set out in subsection (1);*

*To provide a professional opinion is to bring one's training to bear upon one's professional views. Providing a professional clinical opinion is constrained by scientific, ethical and regulatory norms. A practitioner cannot use their professional certification to justify just any view. The opinion must be within the person's scope of practice, it must respect accepted scientific data and clinical standards, and it must respect existing ethical norms as found for example, in the Canadian Medical Association (CMA) Code of Ethics, the CMQ's Code de Déontologie and the practice standards of regulators. Furthermore, to be able to form an opinion about MAiD eligibility requires having the training necessary to develop this competence (**see recommendation 15**). In addition, professional associations and regulatory authorities have responsibilities to ensure that training, mentorship, and organizational structures are available to support competent practice (**see recommendation 1**).*

It is also possible, despite appropriate training, knowledge and additional consultation, assessors will not be able to form an opinion about eligibility for a given case because there is too much uncertainty or complexity whether it concerns incurability, irreversibility, capacity and/or suicidality. In such cases, the practitioner cannot find the person eligible for MAiD. This does not require them to object on conscience grounds but rather to acknowledge the limits of their abilities and the available information in the face of such requests.

SITUATIONS OF INVOLUNTARINESS

One of the eligibility criteria for MAiD is that the person has made, "… a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure." But in some cases, a person's voluntariness may be compromised because of *internal* pressure, namely, through symptoms of their condition. Obvious examples include a requester who has a delusion they must save the world by having MAiD or who experiences command hallucinations telling the person they must die. More subtle examples arise in situations where a person's emotional instability leads them to change their mind frequently about maintaining and withdrawing their request such that the assessor does not know what their wishes are. Another example includes the way in which severe childhood trauma can lead a person to feel hopeless about future change (Ehlers & Clarke, 2000). Assessors need to be aware of these types of internal pressure to request or follow through with MAiD and have training and experience necessary to detect it.

Involuntariness can also stem from a requester's living situation. Here we refer to persons who are living in involuntary circumstances because of their mental disorders: people subject to long-term involuntary hospitalization, or community treatment orders. There are also those in situations of involuntariness not directly arising from a mental disorder—for example, incarceration or Parole Board surveillance. Finally, there are those who experience involuntary placement in nursing homes, often because of neurocognitive disorders.

Being in an involuntary situation may be associated with suffering relating to a mental disorder and/or lead to a person's functional decline (Iudici et al., 2022; Galon & Wineman, 2011). In such cases, the involuntary situation—rather than the medical condition—may be a primary motivating factor in requesting MAiD.

RECOMMENDATION 9: SITUATIONS OF INVOLUNTARINESS

Persons in situations of involuntariness for periods shorter than six months should be assessed following this period to minimize the potential contribution of the involuntariness on the request for MAiD. For those who are repeatedly or continuously in situations of involuntariness, (e.g., six months or longer, or repeated periods of less than six months), the institutions responsible for the person should ensure that assessments for MAiD are performed by assessors who do not work within or are associated with the institution.

3.4 Assessment Process

The majority of MAiD MD-SUMC cases will fall under Track 2 safeguards and require a minimum 90 day assessment period. Because many assessments will require multiple visits, and identifying services that could potentially relieve suffering will take time, requesters and assessors should expect assessment periods will often exceed 90 days. The Expertisecentrum Euthanasie has documented that their assessment process for requesters with mental disorders takes on average ten months (Kammeraat & Kölling, 2020, p. 83).

Provinces and territories should support the development of centralized entry points that can be accessed directly by requesters. Continued development of virtual care as has occurred during the COVID-19 pandemic should be pursued (e.g., secure online platforms, cross-jurisdiction licensure). Given the time required to ensure high quality assessments, both professionals involved in the assessment process and requesters should be supported by staff who will coordinate assessments and facilitate appointments enabling requesters to access care that may alleviate suffering. In addition, an investment of new resources to support the MAiD-related work of assessors, care coordinators, and other healthcare professionals, will be required in provinces and territories where this does not already exist.

Healthcare professionals who have existing therapeutic relationships with requesters should continue to provide them with care during and after the assessment period. The existence of a MAiD team or centralized process should not result in the requester being discharged from existing services. This 'twin-track' approach has been endorsed in Belgium by the VVP. They write, "Any contact in the context of a request for euthanasia must always be focused on death (exploration and evaluation of the request for euthanasia) and on life (recovery-oriented, notwithstanding suffering and limitations, and building a meaningful life)" (VVP, 2017, p. 9). In practical terms, this means that even while a MAiD request is being explored the treating team will continue to work with the requester in the pursuit of therapeutic goals.

We recognize there are a variety of ways of organizing healthcare services, the details of which are best determined by local authorities aware of the specific circumstances in which they operate. Below are a small number of broad practice principles which the Panel considers to be essential in assessing Track 2 cases, particularly where mental disorders are the primary motivating condition.

EXPERTISE

Safeguard 3.1 (e.1) of the *Criminal Code* requires assessors to consult with a medical practitioner or nurse practitioner who has expertise in the requester's condition if at least one of them does not have this expertise. In cases where a thorough appraisal of past interventions is required to establish incurability and irreversibility, and the requester must be given complete information about existing options, it is essential at least one of the assessors have Royal College of Physicians and Surgeons of Canada certification in a specialty that covers the requester's condition. The other assessor of the request may or may not be the person's treating physician or nurse practitioner.

RECOMMENDATION 10: INDEPENDENT ASSESSOR WITH EXPERTISE

The requester should be assessed by at least one assessor with expertise in the condition(s). In cases involving MAiD MD-SUMC, the assessor with expertise in the condition should be a psychiatrist independent from the treating team/provider. Assessors with expertise in the person's condition(s) should review the diagnosis, and ensure the requester is aware of all reasonable options for treatment and has given them serious consideration.

i. Example: When the requester has a mental disorder as a SUMC at least one assessor should be a psychiatrist.

ii. Example: When the requester has multiple mental disorders it may be appropriate that both assessors be psychiatrists.

iii. Example: When the requester has a coexisting mental disorder and physical disorder such as borderline personality disorder and chronic pain one assessor should be a psychiatrist and the other should have expertise in management of pain.

RECOMMENDATION 11: INVOLVEMENT OF OTHER HEALTHCARE PROFESSIONALS

Assessors should involve medical subspecialists and other healthcare professionals for consultations and additional expertise where necessary.

i. Example: A social worker may be needed to provide a comprehensive psychosocial evaluation of a person.

ii. Example: A neuropsychologist may be needed to provide an evaluation of cognitive functions.

iii. Example: Medical subspecialists in the area of the requester's medical condition(s) may also be needed if the treatment options are highly subspecialized and beyond the scope of the general specialist.

INPUT FROM TREATING TEAM AND COLLATERAL INFORMATION

RECOMMENDATION 12: DISCUSSION WITH TREATING TEAM AND COLLATERAL INFORMATION

Recommendation 12a) If the requester's primary healthcare provider is not one of the assessors, assessors should obtain input from that person. When the requester's clinical care is shared by members of a multidisciplinary healthcare team, assessors should solicit their input as well.

Recommendation 12b) With a requester's consent, assessors and providers shall obtain collateral information relevant to eligibility and capacity assessment. This should include reviewing medical records, prior MAiD assessments, and discussions with family members or significant others. Care must be taken to determine that obtaining collateral information will not be harmful to the requester.

Where a requester refuses to give consent to communicate with other clinicians or family members, or access medical records without reason that the assessor believes in good faith are relevant, the assessor may decline to provide/continue with the assessment.

CHALLENGING INTERPERSONAL DYNAMICS

In situations of challenging interpersonal dynamics with a requester, there is a risk MAiD assessors and providers will struggle with the interaction (Nicolini et al., 2020)[41] and accept or reject too readily the individual's request for MAiD. Practitioners should be aware of their own reactions to requesters and seek assistance from colleagues in order to ensure that these reactions do not compromise their judgments about eligibility. In some situations, the best way of ensuring that the request is handled fairly is to withdraw as an assessor. Withdrawing from participating in a request because of challenging dynamics recognizes that not all clinicians and patients work well together and other professionals may work better with a given requester. This is something that occurs in many areas of practice.

F. is a 40-year-old man, who had to stop work due to a combination of physical weakness and loss of ability to plan, organize, and complete tasks as well as changes to memory and concentration. He does not have a low mood. He believes that he has a serious neurological disorder but neurological investigations have all been normal. He requests MAiD on the basis of the neurological disorder and becomes angry when the first assessor suggests that he may be suffering from a psychiatric disorder. He repeatedly emails and calls the assessor's office to insist that the neurological investigations are incorrect. He makes a complaint to the College of Physicians and Surgeons about the assessor. Finally, he calls the assessor's secretary and demands to speak to the assessor saying, "Get him on the phone or you will seriously regret it!"

This type of situation, along with several other aspects of MAiD practice, may not be covered in law or practice standards. Local health authorities will have to establish policies that are appropriate to their contexts. For example, in some locations, when the first and second assessors disagree, the patient is seen by a third assessor. This is not a legal requirement but is determined based on current practices and available resources. Alternatively, local authorities may wish to extend existing policies to include MAiD. For example, a requester making repeated MAiD requests despite no change in circumstances could be covered by existing policies about frequent users. Finally, it is important to note that no practitioner is obliged to participate in MAiD practice. If there are cases whose characteristics do not correspond with an assessor's own values, objecting on conscience grounds may be appropriate. For example, in a situation where a person requests MAiD and one motivation is to hurt a surviving family member, an assessor may not wish to participate.

[41] This was conveyed to the Panel through feedback from assessors and providers with experience in Track 2 cases.

RECOMMENDATION 13: CHALLENGING INTERPERSONAL DYNAMICS

Assessors and providers should be self-reflective and examine their reactions to those they assess. If their reactions compromise their ability to carry out the assessment in accordance with professional norms they should seek supervision from mentors and colleagues, and/or discontinue involvement in the assessment process. The practitioner should adhere to any local policies concerning withdrawal from a MAiD assessment and onward referral.

3.5 Implementation

The remaining six recommendations concern implementation. Several recommendations concern improvements for the functioning of Track 2, and for MAiD overall.

These recommendations concern consultation with First Nations, Inuit, and Métis peoples, training of assessors and providers, prospective oversight, quality assurance, modifications to the federal monitoring system, and research. They respond to specific needs identified in public and professional debates about MAiD. As was done for recommendations 1–13, we will indicate to whom these are directed.

CONSULTATIONS WITH FIRST NATIONS, INUIT, AND MÉTIS PEOPLES

To date, engagement with Indigenous peoples in Canada concerning MAiD has yet to occur. Because of the regional, cultural and historical differences of First Nations, Inuit, and Métis peoples across Canada, the process of engagement will be most impactful if done by regulatory bodies in each province as they develop regional standards of practice for physicians and nurse practitioners. This is not only a requirement of legislative processes in some provinces, it is also necessary to ensure local Standards of Practice reflect the histories, values and perspectives of First Nations, Inuit, and Métis peoples regionally.

RECOMMENDATION 14: CONSULTATIONS WITH FIRST NATIONS, INUIT, AND MÉTIS PEOPLES

Consultation between health regulatory bodies in each province and territory with First Nations, Métis, and Inuit peoples must aim to create practice standards with respect to MAiD MD-SUMC, and MAiD more generally, that incorporate Indigenous perspectives and are relevant to their communities.

Working in collaboration with regional Indigenous health authorities and advisory bodies individually, or through formation of a collective advisory body, could be the most effective and timely way to proceed. Due to the sensitive nature of these consultations, local Indigenous communities may choose to seek advice from Elders and Knowledge Keepers with respect to ancestral, spiritual knowledge and teachings related to assisted dying. Other communities may choose to work with local religious leaders for advice and guidance to support this work.

TRAINING OF ASSESSORS AND PROVIDERS IN SPECIALIZED TOPICS

RECOMMENDATION 15: TRAINING OF ASSESSORS AND PROVIDERS IN SPECIALIZED TOPICS

To support consistent application of the law and to ensure high quality and culturally sensitive care, assessors and providers should participate in training opportunities that address topics of particular salience to MAiD MD-SUMC. These include, but are not limited to: capacity assessment, trauma-informed care and cultural safety.

Several training opportunities have been developed or are under development. For example, the Canadian Association of MAiD Assessors and Providers (CAMAP) is producing a comprehensive set of educational modules, covering many aspects of MAiD practice (Government of Canada, 2021). The CMQ offers a comprehensive course on capacity assessment (not specific to MAiD) (CMQ, 2022). Formal and

informal mentorship and peer supervision opportunities exist e.g., through CAMAP.[42] All healthcare personnel involved in MAiD in Québec can participate in a formal online community of practice.[43]

Recommendation 5 describes the rigour needed for capacity assessments in the context of challenging MAiD cases. As the complexity of capacity assessments for some MAiD requests may not be familiar to assessors, additional training in capacity assessment will likely be necessary. Two additional topics may also require additional training: trauma and cultural safety.

Trauma is often an untreated element of a medical condition for which a patient may seek MAiD (e.g., chronic pain, major depressive disorder). There are many mechanisms by which a trauma history can be related to a MAiD request. For example, it can lead to social isolation, poverty, poor physical health, and abusive relationships, thereby increasing vulnerability (Maunder & Hunter, 2021, pp. 1–7). Trauma can increase the likelihood of self-perceptions of worthlessness, helplessness, and hopelessness and potentially affect capacity (Maunder & Hunter, 2021, pp. 49–58), and it can impact the way a person interacts with health care providers, which can negatively impact their ability to receive good care (Maunder & Hunter, 2021). Trauma and its impacts can go unrecognized, which is why training for MAiD assessors on this topic is essential.

Negative beliefs about ethnicity, race, gender, disability, and religion exist in the healthcare system and can compromise quality of care and lead to structural and societal barriers to accessing care. Cultural safety is "a focus for the delivery of quality care through changes in thinking about power relationships and patients' rights" (Papps, 1996). Cultural safety seeks to "achieve more effective practice through being aware of difference, decolonising, considering power relationships, implementing reflective practice, and by allowing the patient to determine what safety means" (Laverty, McDermott, & Calma, 2017). Training about cultural safety is not only necessary to ensure assessments are conducted with these aspects in mind, but also to assess the appropriateness of past interventions which will be necessary when exploring incurability and irreversibility of a person's condition. If past interventions have been culturally unsafe, these may not be an adequate basis for establishing incurability and irreversibility.

[42] See: **https://camapcanada.ca/about**

[43] The Groupe Interdisciplinaire de Soutien (GIS) is a committee created by the Québec government to support the implementation of the *Act respecting end-of-life care*. Every healthcare institution and territory must have a GIS whose role is to provide clinical-administrative support for MAiD practice. The GISs have formed a community of practice which offers, among other things, an online discussion forum where members can seek assistance with issues arising in MAiD practice.

PROSPECTIVE OVERSIGHT

RECOMMENDATION 16: PROSPECTIVE OVERSIGHT

Given its concurrent jurisdiction in relation to MAiD, the federal government should play an active role in supporting the development of a model of prospective oversight for all or some Track 2 cases that could be adapted by provinces and territories.

Canadian psychiatrists have proposed prospective oversight as an essential mechanism for ensuring appropriate MAiD practice for persons with mental disorders (CPA, 2022; AMPQ, 2020). There are a variety of ways such a system can be organized but the key feature of prospective oversight is a process that ensures assessors complete the necessary assessment steps in compliance with legal requirements in advance of MAiD provision. This mechanism could apply to all Track 2 requests or to those requests which raise questions about incurability and irreversibility, capacity, suicidality and the impact of structural vulnerability. If the latter, a procedure for identifying these cases will have to be developed. It could be assessor-initiated or, where there are MAiD care coordination systems, the care coordinator could use intake information to designate which cases require prospective oversight.

The oversight body could draw upon existing retrospective oversight practices in those provinces and territories which have them (e.g., la Commission sur les soins de fin de vie [Commission on End-of-Life Care] in Québec). For example, a small group of reviewers familiar with the eligibility criteria, safeguards, and assessment process could, in a timely fashion, review the declaration forms[44,45] completed by assessors in their provinces and territories to ensure the information provided is of a nature and quality to satisfy legal requirements.

The purpose of this mechanism is not to make judgments of eligibility. Rather, it is to determine that the assessor has completed the assessment in compliance with legal requirements. If this is not the case, the assessor will be informed of this so that they can complete the assessment. This process need not introduce lengthy delays in the assessment of requests. For example, in Ontario, the Consent and Capacity Review Boards must be convened within seven days to hear a case (2022). In Québec,

[44] In some provinces and territories, clinicians complete forms that provide details about completed MAiD cases. These vary by province and territory.

[45] The Regional Review Committees of the Netherlands (RTE) have developed this type of committee procedure. See: **https://english.euthanasiecommissie.nl/the-committees/committee-procedures**

applications to hospitalize a person involuntarily must be court-authorized and these applications must be presented to court within 72–96 hours of the onset of the person's involuntary status (Government of Québec, 1997, s. 7; Government of Québec, 1991, art. 28). Similar requirements could be introduced for a prospective oversight body.

Such a system has three goals which the Panel believes are not achieved through retrospective oversight. First, it is to improve the quality and safety of assessments in real time. Second, prospective oversight is intended to support practitioners' involvement in the practice of MAiD by providing direct and immediate practice feedback. Finally, this system may also reassure practitioners that their work complies with expected legal standards reducing the fear of criminal sanction. The prospective oversight system could be time-limited if it succeeds in guiding practitioners toward adopting optimal practices. Alternatively, prospective case discussion can be delegated eventually to MAiD coordination systems and become part of the clinical assessment process.[46]

CASE-BASED QUALITY ASSURANCE AND EDUCATION

Current oversight mechanisms in provinces and territories focus on clinicians' compliance with legal eligibility criteria and safeguards. Most do not provide feedback for systems improvement nor observations from their reviews to improve clinicians' practice and knowledge. Furthermore, there are few formal quality improvement processes and no formal case-review based education initiatives that have been identified by the Panel.[47] Mechanisms to make changes to MAiD delivery are informal and dependent on individual initiatives. Similarly, there is little direct feedback to clinicians about their practices. Formalizing these processes could provide opportunities to make systems improvements. It will also provide practitioners ongoing advice regarding practice based on challenges arising in real cases.

RECOMMENDATION 17: CASE-BASED QUALITY ASSURANCE AND EDUCATION

The federal government should play an active role in supporting the development of provincial/territorial systems of MAiD case review for educational and quality improvement purposes.

[46] The Expertisecentrum Euthanasie includes case discussion with practitioners not involved in the assessment of the case prior to providing assistance in dying (Kammeraat & Kölling, p. 99).

[47] There are, however, some informal review processes. For example, the Manitoba MAiD team will discuss cases with team members prior to MAiD administration.

The Regional Review Committees of the Netherlands (RTE) offer an excellent example of case-based education. These committees are responsible for retrospective oversight of EAS but use observations gleaned from their reviews of each case to compile a publicly available, annual report as well as educational practice advice (RTE, 2020). They have also developed a 'Euthanasia Code' which consists of detailed practice points based on their case reviews (RTE, 2018).

MODIFICATIONS TO DATA COLLECTION UNDER THE FEDERAL MAiD MONITORING SYSTEM

In countries that permit assisted dying, public reporting is generally considered to be a critical component in fostering transparency and public trust (External Panel on Options for a Legislative Response to *Carter v. Canada*, 2015, p. 5). Bill C-14 obligated the federal Minister of Health to make regulations necessary to collect and publicly report on information relating to requests for and the provision of MAiD in Canada. A second potential role played by the federal monitoring system is to structure MAiD assessments by signalling to assessors and providers, through mandatory data collection, the essential components of the eligibility criteria and procedural safeguards.

RECOMMENDATION 18: MODIFICATIONS TO DATA COLLECTION UNDER THE FEDERAL MAiD MONITORING SYSTEM

Data related to specific topics (eligibility, supported decision-making, means available to relieve suffering, refusal of means available, and residence and legal status) should be collected in the MAiD monitoring system in addition to data already collected under the 2018 Regulations. These data can be used to assess whether key areas of concern raised about MAiD MD-SUMC and complex Track 2 cases discussed in this report are being addressed by the clinical practices recommended.

On November 1, 2018, regulations setting out the framework for mandatory reporting by physicians, nurse practitioners and pharmacists came into force. The federal monitoring system currently collects data such as total numbers of medically assisted deaths, settings where MAiD is provided, underlying medical condition, sex, and the average age of MAiD recipients. Health Canada produces an annual report using the data collected through the monitoring system to provide an overview of MAiD across Canada. Health Canada is in the process of amending the regulations on MAiD monitoring to align with changes to the federal MAiD legislation made through Bill C-7, and address data gaps that have been identified in the federal monitoring system.

The Panel recommends that data related to the following topics be collected through the federal MAiD monitoring regime to address potential information gaps, and provide insight into whether areas of concern are being addressed:

Eligibility: Incurable illness, disease or disability

In light of the Panel's recommended interpretation of eligibility criteria for MAiD MD-SUMC, reporting requirements should ensure collection of information on length of time the person has experienced the illness, disease or disability as well as types and number of treatments or other interventions attempted. These requirements may also be appropriate for all Track 2 cases.

Supported decision-making

Where supported decision-making measures are implemented, the nature of the support and the reason for doing so should be reported.

Means available to relieve suffering that were discussed with and offered to the person

This field is intended to capture the types of interventions to relieve suffering discussed with and offered to the person. This should also indicate which means would ordinarily have been discussed and offered in similar situations, but were not, as well as the reason why such an offer was considered unnecessary.

Reasons for person's refusal of means to relieve suffering

A person may refuse available means for various reasons. Reasons to be included could be: had already attempted it and found it unhelpful; side effects; culturally inappropriate; financially inaccessible (i.e., must be paid for privately, patient cannot afford it and cannot access public assistance to cover it); past negative experience with the means available; fear of proposed interventions.

Type of residence and legal status of the requester (at time of request, and at the time of the administration of MAiD)

This information will be important in understanding the frequency of requests from those in institutions and/or circumstances of involuntariness. Types of residence should include: hospital, long-term care facility, prison, group home, and shelter. The requester's legal status, voluntary or involuntary, should be identified.

PERIODIC, FEDERALLY FUNDED RESEARCH

Empirical research on the practice of MAiD internationally played a central role in the establishment of Canada's MAiD regime. In fact, one element that enabled the trial judge in *Carter* to reconsider the constitutionality of the criminal prohibition of MAiD, despite a contrary decision in the earlier case of *Rodriguez*,[48] was the existence of empirical data from other countries. These data helped shed light on some key uncertainties about the impact of permitting MAiD (SCC, 2015).

Research has also played an important role in helping address concerns about MAiD practice that have arisen during public debate. For example, concerns that MAiD would substitute for poor access to palliative care has been addressed by academic research, alongside federal and Québec MAiD data collection showing the large majority of MAiD recipients already had access to palliative care (Health Canada 2020, 2021; Downar et al., 2020)

RECOMMENDATION 19: PERIODIC, FEDERALLY FUNDED RESEARCH

The federal government should fund both targeted and investigator-initiated periodic research on questions relating to the practice of MAiD (including but not only MAiD MD-SUMC).

While the federal MAiD monitoring system can provide a quantitative snapshot of certain aspects of MAiD, the Panel believes that additional research about MAiD practice exploring areas that cannot be identified through this system should be undertaken. For example, if few MAiD assessors and providers wish to work with requesters who have MD-SUMC as has been recently reported in the Netherlands (van Veen & Widdershoven, 2021), the reasons for low participation and the impact of low participation on the practice will require further study. Because research about the functioning of the system plays such an important role in shedding light on actual practice, it is crucial this work be subject to regular, periodic calls for applications financed by federal research funds.

[48] In 1992, Sue Rodriguez, a woman living with amyotrophic lateral sclerosis (ALS), applied to the Supreme Court of British Columbia to have the *Criminal Code* prohibition on assisted suicide declared unconstitutional. The case was ultimately appealed to the SCC, which ruled by a narrow (5-to-4) majority that the prohibition against assisted suicide was not in violation of the *Charter* (SCC, 1993).

4.0 ISSUES REQUIRING FURTHER CONSIDERATION

There are three specific groups of requesters within the Panel's scope that we believe require additional consideration beyond the life of the Panel. The first concerns persons with mental disorders who are elderly and frail or have an accumulation of medical problems; the second concerns persons with intellectual disabilities; and the third concerns requesters in the carceral setting.

4.1 Elderly Persons With Mental Disorders

One of the implications of the current legislation is that a physically frail elderly person or an elderly person with multiple medical comorbidities seeking MAiD primarily due to a mental disorder could be eligible under the Track 1 safeguards (safeguards applicable when natural death is reasonably foreseeable), rather than the more prolonged and detailed Track 2 safeguards.

The case of *A.B. v. Canada*, which predated the recent changes in Bill C-7, concerned a 77 year old woman with severe suffering from osteoarthritis, a condition that would not on its own make her death reasonably foreseeable. Justice Perrell explained that the term 'natural death' as used in the legislation need not be "connected to a particular terminal disease or condition and rather is connected to all of a particular person's medical circumstances" (Ontario Superior Court of Justice, 2017, para 81).

Under current MAiD law a person with physical conditions accepted as a "serious and incurable illness, disease or disability," but whose advanced state of irreversible decline and enduring, intolerable suffering are primarily due to a mental disorder, could meet the legislative definition of a grievous and irremediable medical condition. The interpretation of the original MAiD law seemed to allow age to be a factor relevant to the designation of RFND (Senate of Canada, 2016). Thus, two people seeking MAiD for a mental disorder—one who is frail or has multiple medical comorbidities and is elderly, and one who is not—might be approached differently. The one who is not elderly could only proceed under Track 2 and the protections it affords, and the one who is elderly could proceed under Track 1.

Whether Track 1 or 2 is the better approach in the case of an elderly person will depend upon the case. However, some assessors and providers may think they are required to adhere to Track 1 in such cases. What flexibility—if any—assessors have to select the Track should be clarified for practitioners and requesters.

Although this section addresses elderly persons because they are more likely to be frail or have multiple medical comorbidities than others, the reasoning here could apply to younger people with the same physical health profile.

4.2 Persons With Intellectual Disabilities

As noted above, the federal government has stated that people with neurodevelopmental and intellectual disabilities are not covered by the mental illness exclusion clause. This means that they may request and be considered eligible for MAiD at present. However, some of the concerns raised about mental disorders (such as questions about capacity, voluntariness, and structural vulnerabilities) could also apply to persons with intellectual disabilities.

The Panel identified four possible scenarios of requests involving this group of persons:

1. a person with an intellectual disability and a comorbid physical condition whose natural death is reasonably foreseeable (e.g., a person with advanced terminal cancer);
2. a person with an intellectual disability and a comorbid physical condition whose natural death is not reasonably foreseeable (e.g., a person with a epilepsy or a person whose intellectual disability is part of a clinical syndrome with both cognitive and physical aspects);
3. a person with an intellectual disability and a mental disorder; and,
4. a person with an intellectual disability alone.

The first two categories of people could potentially be eligible for MAiD under Bill C-7 on the basis of their physical condition if they meet all the eligibility criteria. Such requests could proceed under the Track 1 and Track 2 safeguards respectively. Persons in the third and fourth categories may also be potentially eligible if their intellectual disabilities are taken to be "serious and incurable illness, disease or disability," resulting in an "advanced state of irreversible decline in capability," and enduring, intolerable suffering and if the other requirements such as age, capacity and voluntariness are met.

In the Netherlands, a small number of requests for euthanasia have been accepted for people with intellectual disability or autism spectrum disorder, several of whom did not have physical co-morbidities (Kammeraat & Kölling, 2020, p. 100; Tuffrey-Wijne et al., 2018).

The Panel was constituted to look at safeguards appropriate to MAiD for mental illness, and not for neurodevelopmental or other intellectual disabilities even if many of the same issues arise in such cases. Given the lack of subject matter expertise for this topic amongst the Panel membership, there is a need for the particular issues related to MAiD for persons with intellectual disabilities to be considered further and addressed in collaboration with people with lived experience and their supporters.

4.3 Requesters Who Are Incarcerated

The prison population offers additional challenges when it comes to MAiD MD-SUMC. First, the prevalence of mental disorders is high relative to the general population (Cameron et al., 2021; Kouyoumdjian et al., 2016; Kurdyak et al., 2021). Access to adequate care may be limited and dangerous and stressful conditions may be present (Office of the Correctional Investigator of Canada, 2019). The Office of the Correctional Investigator (2020) and Driftmier and Shaw (2021) also noted concerns about voluntariness and confidentiality related to MAiD requests and assessments by inmates, although this is not specific to MAiD MD-SUMC.

In 2018–19, there were 14,071 individuals in federal custody and 23,783 individuals in provincial/territorial custody (Malakieh, 2020). Adults serving custodial sentences of two years or more are housed in federal prisons administered by the CSC. Almost half (49.3%) of this population is serving a sentence of less than five years while almost one quarter (24.3%) is serving an indeterminate sentence (Public Safety Canada, 2020). Adults serving custodial sentences less than two years and those held while awaiting trial or sentencing, as well as those serving community sentences, fall under the purview of provincial and territorial correctional services programs (Malakieh, 2020). The average length of stay in these institutions is less than three months. As some prisoners in federal prisons are in situations of long-term involuntariness, federal prisons are of most relevance to this report.

As of March 31, 2022, there have been five assisted deaths of prisoners in federal prisons since Bill C-14 came into force in June 2016 (e-mail communication with CSC Health Services). There are approximately 50 deaths from all causes per year in CSC's sites resulting in about 250 deaths since 2016 (Public Safety Canada, 2020). MAiD deaths represent approximately 2% of total federal prison deaths. The Canadian rate of MAiD Deaths in 2020 was 2.5% of all deaths.

The Panel solicited input from the medical leadership of the CSC in order to better understand the situation in federal prisons. In terms of policies concerning care and MAiD, these colleagues pointed us to the *Corrections and Conditional Release Act* (CCRA), its MAiD policy, and the CSC Integrated Mental Health Guidelines. The CCRA states that individuals under supervision of CSC be provided with essential health care and have reasonable access to non-essential health care (Government of Canada, 1992). The provision of health care must conform to professionally-accepted standards (Government of Canada, 1992). This is interpreted to mean that inmates are entitled to receive the equivalent quality and type of care as exists in the community (Cameron et al., 2021). The MAiD policy requires that the second assessor be from outside the institution while the first assessor is from within (CSC, 2017). It also requires that MAiD take place outside of a CSC facility[49] although there has been at least one case of MAiD in prison at the individual's request (Office of the Correctional Investigator of Canada, 2020; Driftmier & Shaw, 2021). The CSC is not aware of any instance where a person has requested MAiD as a means to avoid completing their sentence.

With respect to MAiD MD-SUMC for their patient population, these colleagues expressed many of the same concerns as have been identified in this report, namely difficulties establishing incurability and irreversibility, uncertainty about capacity and suicidality. They also questioned the voluntariness of some requests, given the fact of imprisonment. In light of the clinical specificity of the prison population and context, they believe that MAiD assessors in prisons should have some knowledge of the setting and the mental disorders most prevalent within prisons.

At present, data collection about MAiD in prisons is limited. The federal monitoring system does not identify MAiD for prisoners when the procedure takes place outside correctional facilities (as generally they do in compliance with the CSC's MAiD policy). In order to follow the prevalence of MAiD for prisoners, we recommend a modification to the federal monitoring system to this effect (**see recommendation 18**).

The Panel was constituted to look at safeguards, protocols and guidance appropriate to MAiD for mental illness, and prisoners with mental illness are within scope. Recommendation 9 applies to this population. However, given the lack of subject matter expertise on this topic amongst the Panel membership, further reflection will be required by policymakers, advocates, and people with lived experience as to the necessity for additional protocols and guidance in this area.

[49] In exceptional circumstances, at the request of the inmate, a Treatment Centre or a Regional Hospital may be used, provided:

1. an exception has been approved by the Assistant Commissioner, Health Services, and
2. the procedure includes a health professional external to CSC.

5.0 CONCLUSION

In a MAiD regime based on a person's suffering from a medical condition, singling out certain diagnoses for exclusion does not map easily onto the complexity of illness and human experience. Furthermore, focusing only on the vulnerabilities of one group—persons with mental disorders—can neglect the potential vulnerabilities of many other requesters. The concerns about the impact of these vulnerabilities on decisions to request MAiD are legitimate, regardless of a person's diagnosis, and they require ongoing serious consideration and effort from clinicians, regulators, professional organizations, community and advocacy organizations and governments.

This report is the beginning of a process, not the end. The Panel has offered initial reflections on how to address some of the complexity existing in certain areas of MAiD practice. More work will be required by many actors in Canadian society to ensure that MAiD for persons with mental disorders, and indeed MAiD practice more broadly, evolves in a way that responds appropriately to those Canadians who wish to avail themselves of this option.

APPENDIX A: TERMS OF REFERENCE

Preface

On September 11, 2019, the Superior Court of Quebec ruled in favour of two plaintiffs (Jean Truchon and Nicole Gladu) who had challenged the *Criminal Code* medical assistance in dying (MAiD) eligibility requirement that an individual's natural death be reasonably foreseeable as well as Quebec's provincial requirement for a person to be at the end of life (*Truchon v. Attorney General of Canada*). The governments of Canada and Quebec did not appeal the decision.

Bill C-7 *An Act to Amend the Criminal Code (Medical Assistance in Dying)* was introduced to respond to the Superior Court of Quebec decision in Truchon. The Bill received Royal Assent on March 17, 2021. This legislation expands access to MAiD to include individuals whose death is not reasonably foreseeable, while also amending other aspects of the safeguards included in the law.

Bill C-7 excludes individuals with a mental illness as their sole underlying medical condition from access to MAiD, but the exclusion is subject to a 24 month sunset clause. The Government of Canada recognizes that mental illnesses are serious conditions that can cause suffering on par with that of physical illnesses. At the same time, it acknowledges that there are multiple complexities associated with allowing MAiD for individuals suffering solely from mental illness. These include concerns as to whether a person's condition can be assessed as "incurable" or "irremediable," challenges in assessing capacity, and disentangling the common symptom of a desire to die from a genuine MAiD request arising from enduring and unbearable suffering. In addition, there are concerns that permitting MAiD for persons with severe mental illness might be regarded as running counter to, and/or undermining, public policy and initiatives aimed at reducing suicide and suicidal ideation, particularly among groups or communities with relatively higher rates of suicide.

In recognition of these challenges, the Bill includes an obligation for the Minister of Health and the Minister of Justice and Attorney General of Canada (Ministers of Health and Justice) to initiate an independent expert review "respecting recommended protocols, guidance and safeguards to apply to requests for medical assistance in dying by persons who have a mental illness." The report of the experts' conclusions and recommendations must be submitted to the Ministers by March 17, 2022 (i.e., within one year from the date of Royal Assent of Bill C-7). This work will help ensure that practitioners are equipped to assess these requests in a safe and compassionate way based on rigorous clinical standards and safeguards that are applied consistently across the country.

The role of the Expert Panel is to provide independent advice on safe and appropriate approaches to the assessment and provision of MAiD to individuals living with mental illness who are seeking this avenue to end their intolerable suffering and to recommend potential legislative safeguards. Its role is not to debate whether or not persons with a mental illness as their sole underlying medical condition should be eligible for MAiD.

Mandate

The mandate of the Expert Panel is to make recommendations with respect to:

- Protocols and guidance for the assessment and provision of MAiD for persons with a mental illness for use by national, provincial and territorial health professional bodies and medical practitioners.
- Additional safeguards for inclusion in federal legislation to support the safe implementation of MAiD for persons with a mental illness.

This mandate includes considerations for persons with mental illness as their sole underlying medical condition and those with concurrent mental and physical illness.

The Expert Panel will submit a report containing its conclusions and recommendations no later than 12 months after the coming into force of Bill C-7 (i.e., March 17, 2022). The Ministers of Health and Justice are obligated in Bill C-7 to table the report in each House of Parliament within 15 days of receiving it. This will provide time for the Government to consider introducing legislative amendments to the federal MAiD regime and for Parliamentarians to consider those proposals, and for professional regulatory bodies and associations to develop appropriate guidance and resources prior to the sunsetting of the exclusion for mental illness on March 17, 2023.

The Expert Panel will take into consideration, and build upon, previous reports on the topic of MAiD for persons with mental illness and their sources, such as the report by Council of Canadian Academies on this subject, reports of health professional associations and other relevant documents.

The Expert Panel will also take into consideration expert testimony and briefs on the topic of MAiD for persons with mental illness delivered during the review of Bill C-7 undertaken by the House of Commons Standing Committee on Justice and Human Rights and the Senate Standing Committee on Legal and Constitutional Affairs.

Recognizing that the Special Joint Committee on Medical Assistance in Dying is undertaking its Parliamentary Review of MAiD legislation during the same time period as the Expert Panel and will also examine the issue of mental illness (as required by Bill C-7), the Expert Panel will be kept apprised of relevant developments as this process unfolds.

Governance

The Expert Panel operates under the general parameters of the **Health Canada Policy on External Advisory Bodies**.

The Expert Panel is responsible for the content of its final report, including a summary of its process, key evidence and findings, and its conclusions and recommendations on the two mandated topics. The Panel's report is to be submitted to the Ministers of Health and Justice.

The Expert Panel will be supported by a federal Secretariat located in Health Canada.

Membership Nomination Process

Prospective members of the Expert Panel will be identified through a targeted solicitation process. The goal of this process is to ensure that together, members have a range of knowledge and expertise, and embody the array of professional experience and perspectives required to fulfill the Panel's mandate. The Government of Canada promotes diversity and inclusiveness in Expert Panel membership.

Members of the Expert Panel are appointed by the Ministers of Health and Justice. They are appointed at pleasure, and appointments may be ended without cause or consultation.

Membership Considerations

The Expert Panel will be comprised of approximately 8–12 members.

Together, members of the Expert Panel will reflect a range of disciplines and perspectives, including clinical psychiatry, MAiD assessment and provision, law, ethics, health professional training and regulation, mental health care services, as well as lived experience with mental illness.

To preserve the independence of the federal government as a decision maker, a federal employee can neither chair nor be a member of the Expert Panel, and cannot participate in the formulation of the Expert Panel's advice to the Ministers of Health and Justice.

Affiliations and Interests

All members are required to complete and return the Affiliations and Interests Declaration Form. The personal information in a completed Affiliations and Interests Declaration Form is considered confidential and protected in accordance with the federal *Privacy Act and Access to Information Act*. A summary of the information in this form may be made public with the permission of the member who signed it.

As a condition of appointment, an Expert Panel member must prepare and give Health Canada permission to publish a brief biography and summary of expertise, experience and affiliations and interests on its website and through additional means, as needed.

Members must update their declaration in writing whenever their situation changes during the course of their term on the Expert Panel.

Confidentiality

Specific advice to the Ministers of Health and Justice will be treated confidentially by the Expert Panel members. Expert Panel members will be required to treat the final report as confidential until it is tabled in Parliament by the Ministers of Health and Justice.

All Panel members or others attending any Panel meeting must sign a Confidentiality Agreement before participating in the Expert Panel as a member, presenter, or observer. The Confidentiality Agreement prohibits the disclosure of any confidential information received through the Expert Panel, including information received orally or in writing, through email correspondence, telephone calls, print materials, meeting discussions, etc.

Indemnification of Members: When Serving as Volunteers

All members serve on a volunteer basis. Health Canada undertakes to provide its volunteer Expert Panel members with protection against civil liability provided the volunteer member acts in good faith, within the scope of their duties as a panel member; and does not act against the interests of the Crown.

Recommendations provided to the Ministers of Health and Justice are based on Expert Panel discussions and must have the general endorsement of the majority of committee members. Members act collectively as advisors to the Ministers with respect to the

mandate of the Expert Panel but they are not final decision-makers. The Ministers of Health and Justice have the ultimate responsibility and accountability for any decisions or actions resulting from the recommendations received from the Expert Panel.

Travel and Expenses

It is expected that most meetings will take place via tele- or video-conference, particularly in the near term, given public health measures in place during the COVID-19 pandemic. Should these circumstances change during the Expert Panel's tenure, members would be reimbursed for expenses incurred on approved travel, such as trip costs and accommodation, according to the Treasury Board's Directive on Travel, Hospitality, Conference and Event Expenditures.

Resignation Process

It is preferable for a member to provide 14 days' notice of the intent to resign. The resignation letter must be in writing and be addressed to the executive secretary and to the Chair and Vice-chair. The letter should state the effective date of the resignation.

Roles and Responsibilities

Expert Panel Members

Members of the Expert Panel are expected to interact in an unbiased, professional, respectful, and fair way with the Chair and Vice-chair, other Expert Panel members, the Secretariat, government officials, stakeholders, and the public. They may not use their position on the Expert Panel for private gain or for the gain of any other person, company, or organization. Members of the Expert Panel have a responsibility to the Government of Canada and, by extension, to Canadians, to give their best advice based on their professional judgement and the available evidence.

Other responsibilities include:

- Actively participating in Expert Panel meetings and discussions, which may include email exchanges, conference calls, videoconferencing and webinars.
- Becoming familiar with key documents and issues relevant to their mandate, through the review of written documents provided in advance of meetings.
- Applying their expertise and experience, and considering all input received in the course of developing advice for the Government of Canada.

- Actively contributing to the development of reports drafted as part of the Expert Panel's mandate.
- Notifying the Secretariat and the Chair and Vice-chair of any changes in their affiliations and interests related to the Expert Panel's mandate during their tenure.
- Directing any media inquiries to the Secretariat and the Chair and Vice-chair.

Chair and Vice-chair

The Expert Panel will be led by Chair and Vice-chair—representing the fields of psychiatry and law. The Chair and Vice-chair of the Expert Panel have additional responsibilities, including:

- Working with the Secretariat to develop a plan for the work of the Expert Panel and then leading the Expert Panel to meet those objectives.
- Chairing meetings of the Expert Panel.
- Facilitating a full and frank discussion among Expert Panel members in fulfillment of the Expert Panel's mandate, including in formulating its recommendations, advice, or report to Health Canada
- Ensuring that discussions of the Expert Panel remain in line with its mandate.
- Indicating when information and discussions are considered confidential and clarifying expectations regarding both protected information and Panel deliberations.
- Seeking consensus amongst members of the Expert Panel, and if there is not agreement, ensuring that the diversity of opinion is noted in the meeting records and reports.
- Participating as witnesses in the Parliamentary Review of MAiD legislation, if required.
- Providing at least one interim progress report to the Ministers (by approximately November 2021– exact date to be determined)
- Providing a briefing to senior officials on the conclusions and recommendations contained in the final report, prior to its submission to Ministers.
- Presenting the Expert Panel's final report to the Ministers.
- Supporting, in any other way, the fulfillment of the Expert Panel's mandate.

Secretariat

The Secretariat of the Expert Panel is housed in Health Canada's Strategic Policy Branch. The Secretariat is the administrative liaison between members of the Expert Panel and the departments of Health and Justice.

The Secretariat provides leadership and strategic advice in the management of the Expert Panel and works closely with the Executive Secretary, the Chair and Vice-chair, the departments and Ministers' Offices (Health and Justice). The Secretariat is also a resource for members of the Expert Panel.

Additional responsibilities of the Secretariat include:

- Coordinating the process of soliciting members.
- Coordinating the preparation and distribution of materials for Expert Panel members, observers, and others.
- Attending and providing support during Expert Panel meetings.
- Providing administrative support to Expert Panel members.
- Supporting public access to information about the Expert Panel, as appropriate.
- Preparing and circulating records of decision to members for review and confirmation.
- Supporting the preparation of the Expert Panel's interim progress report.
- Supporting preparation of the Expert Panel's final report.
- Undertaking any tasks delegated to it by the Executive Secretary
- Report to the Executive Secretary on the activities of the Expert Panel
- Carrying out any additional duties as appropriate to support the activities of the Expert Panel.

Executive Secretary

The Expert Panel's Executive Secretary is a senior Health Canada executive who provides guidance to and makes decisions about the administration and operation of the Expert Panel. The Executive Secretary works closely with the Chair and Vice-chair, Secretariat and Department of Justice officials.

The Executive Secretary advises the Expert Panel at the beginning of each meeting on next steps.

The Executive Secretary may delegate these responsibilities to another senior staff member of Health Canada.

Media and Communications

Members are expected to notify the Secretariat of any media enquiries related to the Expert Panel's work and direct such enquiries to the Secretariat.

All media requests related to the Expert Panel's statements or activities will be directed to Media Relations, Health Canada, who will coordinate responses with its counterpart at the Department of Justice and the designated media spokesperson.

Management and Operations

Transparency

The Government of Canada is committed to transparency as an operating principle. Transparency of the Expert Panel is served by:

- Ensuring that meeting schedules are predictable, where possible.
- Posting information about the Expert Panel on Health Canada's website, including, but not limited to, the terms of reference, the membership list and biographies, the declaration of affiliations and interests, and the final report after it is tabled in Parliament.

Meeting Agendas

The Chair and Vice-chair, in consultation with the Executive Secretary, or his/her delegate, and with input from the members, prepare meeting agendas, including identifying questions and issues for discussion.

Meeting Notices and Invitations

All meetings are scheduled at the call of the Chair and Vice-chair, and in consultation with the Executive Secretary or Secretariat. Meetings may be limited to Expert Panel members only or may be opened to presenters and observers by invitation.

The Secretariat sends out the meeting invitations.

Frequency and Type of Meetings

Expert Panel meetings will generally be scheduled on a monthly basis, with the likelihood of additional meetings to consider specific work streams associated with its mandate. Meetings will be held primarily by video- or tele-conference.

Observers

The secretariat, in consultation with the Chair and Vice-chair, may allow or invite individuals or organizations to observe a meeting or part of a meeting. Observers may not provide input on agenda items or participate in the discussions, unless specifically invited to do so by the Chair and/or Vice-chair, or the Secretariat in consultation with the Chair/Vice-chair.

Invited Presenters

The Secretariat or the Chair and/or Vice-chair, in consultation with the Executive Secretary, may invite individuals with particular expertise or experience to provide input on a specific topic or agenda item. Invited guests may participate in the discussions if the Chair and/or Vice-chair specifically invite them to do so, but they do not participate in the development, review or revision of reports.

Requirements of presenters and observers

Health Canada may require an invited presenter or observer to complete:

- *Declaration of Affiliations and Interest Form*
- *Confidentiality Agreement*
- *Personnel Screening, Consent and Authorization Form*

Deliberations and reports

Advice from the Expert Panel will be provided to the Ministers of Health and Justice in the form of a final report.

The Expert Panel is encouraged to reach a consensus on its formal advice whenever possible. When a consensus is not possible, the meeting record will reflect the diversity of opinions.

The Expert Panel must have quorum when making recommendations to the Ministers of Health and Justice. Quorum is one half of the members plus one.

Records of proceedings will be prepared by the Secretariat and circulated to members for review and confirmation.

The Expert Panel's final report will be posted on Health Canada's website, once tabled in Parliament.

APPENDIX B: PANEL MEMBERSHIP AND BIOGRAPHIES

MONA GUPTA (CHAIR)

Mona Gupta MD CM, FRCPC, PhD is a psychiatrist at the Centre Hospitalier de l'Université de Montréal and Associate Clinical Professor in the Département de Psychiatrie et d'Addictologie at the Université de Montréal. She is an active researcher in ethics and philosophy of psychiatry and serves as a Senior Editor of the journal *Philosophy, Psychiatry and Psychology*. She was Chair of the MAiD advisory committee for the Association des Médecins Psychiatres du Québec and co-author of its December 2020 discussion paper on assisted dying and mental disorders. She was also a member of the Council of Canadian Academies Expert Panel on MAiD: Working Group on MAiD where a Mental Disorder is the sole underlying medical condition whose report was tabled in the Parliament of Canada in December 2018.

ROSE M. CARTER (VICE-CHAIR)

Rose Carter is counsel at Dentons Canada LLP (Edmonton) in the Firm's health law field, bringing more than 30 years' experience in health law. She assists various medical practitioners as well as scientific professionals, navigate the regulatory requirements of private and public practice. She has provided legal advice on numerous occasions to medical practitioners on Medical Assistance in Dying since its legalization. Throughout her three decades of practice, Rose, as a litigator, has appeared before all levels of courts in Alberta, as well as before various administrative law tribunals.

To complement her law practice, Rose devotes substantial time as an active and valuable member of the legal and medical community. She is an Adjunct Professor in the Faculty of Medicine and Dentistry at the University of Alberta, where she lectures on medical legal issues to faculty members, practicing physicians, residents and students. She serves the medical communities across Canada as Chair of the Appeals Committee of the Medical Council of Canada and as Council member of the Royal College of Physicians and Surgeons of Canada. She is a member of the John Dossetor Health Ethics Centre, Clinical Service, Edmonton.

Rose has been commended for her extensive knowledge and experience in a variety of respected publications and is the recipient of the Women in Law Leadership Award: Leadership in the Profession (Private Practice).

JENNIFER A. CHANDLER

Jennifer A. Chandler is a Full Professor in the Faculty of Law, cross-appointed to the Faculty of Medicine, University of Ottawa. She holds the Bertram Loeb Research Chair (2016 to present). Prof. Chandler is a member of the Centre for Health, Law, Policy and Ethics (interim director 2020–2021), the Centre for Law, Technology and Society, and the University of Ottawa Brain Mind Research Institute. She holds degrees in law from Queen's University (Canada) and Harvard University. She was also a member of the government-appointed Council of Canadian Academies' expert panel that completed its review of Canada's medical assistance in dying legislation in 2018. She is the co-editor of the 2016 book *Law and Mind: Mental Health Law and Policy in Canada* (LexisNexis Canada), and has taught mental health law and neuroethics to Juris Doctor and graduate law students since 2012. Prof. Chandler provides advice on the ethical, legal and societal aspects of neuroscience and mental health research as a member of the Advisory Board to the Canadian Institutes of Health Research's Institute for Neurosciences, Mental Health and Addiction. She also serves on international editorial boards in the field of law, ethics and neuroscience, including *Neuroethics*, the Springer Book Series Advances in Neuroethics, and the Palgrave-MacMillan Book Series *Law, Neuroscience and Human Behavior.* She runs an international discussion group called Mind-Brain-Law, which brings together students, scholars and practitioners spanning science, medicine, humanities and social sciences.

ELLEN COHEN (RESIGNED DECEMBER 28, 2021)

With her own personal experience of mental illness and as a supportive family member, Ellen always knew she would be a helper. As an advocate, educator and organizer, she has enjoyed a long career in advocacy, social work and working in mental health. She holds a degree in Sociology and Social Welfare, and a diploma in Social Services and is a lifelong learner. Ellen has held positions experiencing all levels of government; as a social service worker with the city of Toronto, Ontario Probation and Parole as a probation officer and as an early childhood educator. She has worked for over 30 years in community mental health, facilitating and supporting the development of the Ontario infrastructure of consumer—survivor peer led organizations.

She has volunteered in the community on a variety of boards and committees and shares a long history with the National Network for Mental Health (NNMH). She has a keen understanding of mental health across the lifespan and the issues facing people living in Canada with mental illness and the intersection of mental illness within the disability and deaf communities. Ellen is the current co-chair of the Canadian Alliance for Mental Illness and Mental Health (CAMIMH) where she represents the consumer perspective as a member of the NNMH.

Shifting their focus to the disability community, NNMH now plays a pivotal role in bridging the mental health community to the larger disability movement, and bringing awareness of the intersections of disability into the mental health sector. This shift into the disability community has enabled the NNMH to become actively involved human rights and social justice work alongside our partners from the disability community working on issues relevant to the good health and well being of all Canadians from coast to coast to coast.

JUSTINE DEMBO

Dr. Justine Dembo, MD, FRCPC is an Assistant Professor in the University of Toronto's Department of Psychiatry and a staff psychiatrist at Sunnybrook Health Sciences Centre in Toronto, where she specializes in obsessive-compulsive disorder at the Thompson Anxiety Disorders Centre. She completed her medical education and residency in psychiatry at the University of Toronto. She has been a MAiD assessor since the *Carter v. Canada* decision in 2015, and she is a Mentor with the Canadian Association of MAiD Assessors and Providers for other clinicians dealing with complex assessments. She has been researching, teaching, and publishing on the intersection of MAiD and mental illness since 2009, and she has been an invited speaker at numerous conferences and educational events. She was an Expert Witness in the *Truchon v. Canada* and *Lamb v. Canada* cases, and she submitted a Brief and testified at the Senate hearings regarding Bill C-7 in February 2021.

She is also a member of the Canadian Psychiatric Association (CPA) Working Group on MAiD and mental illness, and co-author of a Discussion Paper produced by the CPA in 2020. She has been a member of the Joint Centre for Bioethics MAiD Working Group and Community of Practice since 2015. She co-facilitates MAiD seminars for University of Toronto residents in psychiatry on their Consultation-Liaison rotations. She is also currently the Principal Investigator on a qualitative study examining MAiD for sole mental illness, and a co-investigator on another qualitative study examining MAiD in complex chronic medical conditions.

SARA GOULET

Dr. Sara Goulet is a Métis family doctor who grew up in the Red River Valley. Like her father, a bush pilot, she travels all over northern Manitoba and the Kivalliq region of Nunavut. She has been providing health care services to First Nations and Inuit communities since 2007. Dr. Goulet provides leadership and support to the fly in doctors at Ongomiizwin Health Services. To better service these communities, she also works to maintain her knowledge, skills and relationships by providing hospitalist services at the Health Sciences Centre in the Clinical Assessment Unit and the Surgical Intensive Care Unit.

Dr. Goulet is currently the Associate Dean of Admissions for the Max Rady College of Medicine at the University of Manitoba. In this role, she hopes to continue to foster diversity in the College and to explore ways to support projects that increase the number of First Nations, Inuit and Métis students who can access medical school.

In addition to these roles, Dr. Goulet joined the *MAiD team* in Manitoba with the purpose of examining how to integrate *Indigenous Ways of Knowing* into the process of assessing, treating and supporting Indigenous patients in this time of transition. This work directly aligns with the vision Dr. Goulet has for a health care system where Indigenous patients are respected, honored and recognized for the knowledge they bring to health and wellness that enhances the Western Biomedical perspective. She believes in the integration of Western and Indigenous knowledge systems is the key to healing, hope and reconciliation.

KAREN HETHERINGTON

Karen Hetherington, BA, MS is President of the Canadian Mental Health Association, National and the Québec Division. Her career focus is on community mental health prevention and promotion and mental health policy. She has a rich background in the clinical and administrative aspects of the mental health eco-system in both the public and the non-profit sector.

A recently retired faculty lecturer from the McGill University School of Social Work, she continues to teach in the Mental Health certificate program in the Faculty of Continuing Education of the University of Montreal. She has bachelor's degree in sociology and a master's degree in psycho-education from the University of Montreal.

Founding president of many community organizations in Québec, she is the director of OPTION MILIEU, which specializes in service planning and training in mental health. She was a founding member of the Association québécoise pour la réadaptation psychosociale (AQRP) and is on the Board of Directors of the Regroupement québécois des organismes communautaires en psyochotherapie. For more than 15 years, she was a Senior Consultant to the World Health Organization (WHO) in mental health policy development in Latin America and the Caribbean.

JEFFREY KIRBY (RESIGNED APRIL 27, 2022)

Dr. Jeffrey Kirby is a (retired) Professor in the Department of Bioethics, Faculty of Medicine, Dalhousie University. He has an educational background and professional experience in medicine, philosophy and health care ethics. His academic activities and research interests include the ethics analyses of complex health care practices, ethics elements/dimensions of medical assistance in dying (MAiD), mental health care ethics, critical care ethics, organ donation and transplantation ethics, organizational ethics, and socially-just, health policy development through the use of innovative, deliberative engagement methodologies.

Dr. Kirby has published a set of academic papers in high-impact, international, bioethics journals on a variety of MAiD-related topics including: assisted dying for suffering arising from mental health conditions, morally-relevant distinctions between paradigm and non-paradigm MAiD circumstances, meso- and macro-level (MAiD-related) health policy development, organ donation after MAiD and institutional conscientious objection to MAiD. He made several, virtual and written, *Bill C-7* related submissions to the Senate Committee on Legal and Constitutional Affairs regarding matters/issues of relevance to the potential consideration of mental health disorders as sole-qualifying conditions for MAiD in Canada.

Dr. Kirby has past practice experience in the direct delivery of mental health care services as a university-based physician-psychotherapist. In furtherance of the social-justice advocacy of (the late) Marion Ernst Kirby, he is actively engaged in volunteer commitments pertaining to the pragmatic provision of health- and social-support services to members of historically-marginalized and otherwise disadvantaged social groups, including persons with severe and persistent mental illness and inadequately housed persons.

TREVOR MOREY

Trevor Morey (preferred pronouns are he/him) is a family medicine and community based palliative care physician based in Toronto, Ontario. He works as a physician with the PEACH (Palliative Education and Care for the Homeless) team based out of the Inner City Health Associates, the Temmy Latner Centre for Palliative Care and Casey House Hospital. He is a lecturer at the Department of Family and Community Medicine at the University of Toronto.

He is a member of the Board of Directors of the Inner City Family Health Team and the communications lead for Health Providers Against Poverty, a community based advocacy organization. He is currently a member of a working group within Correctional Service Canada to improve access to palliative care services for people within the correctional system. Trevor is the research lead for the PEACH team and is passionate about providing equitable access to palliative care.

Trevor received his medical degree from Queen's University and completed his residency training in family medicine with enhanced skills in palliative care at the University of Toronto and is a member of the Canadian College of Family Physicians.

LEORA SIMON

Leora Simon has participated in patient/community engagement initiatives in healthcare and research for over 10 years as both a person with lived experience and research coordinator/assistant. Leora currently serves as chair of the National Council of Persons with Lived Experience (NCPLE), an advisory committee to the National Office of the Canadian Mental Health Association and National Board of Directors. As part of her role, she also represents the voice of people with lived experience of mental illness on the National Board. Leora is also a member of the Clinical, Qualitative and Quantitative Research (CQQR) Technical Committee, a group working to develop national standards for the conduct of human research.

Leora completed her MSc in Experimental Medicine (basic biomedical research) at McGill University. She currently works as a Research Administrator/Coordinator in the Department of Epidemiology and Biostatistics and Occupational Health at McGill University. Leora endeavors to combine her scientific knowledge, research training and lived experience to improve quality, effectiveness and access to person centred health and community services for people in situations of vulnerability.

DONNA STEWART

Dr. Donna Stewart CM, MD, FRCPC is a University Professor at the University of Toronto, with a primary appointment to Psychiatry and cross appointments to Medicine, Surgery, Obstetrics and Gynecology, Anesthesiology and Pain Medicine and Family and Community Medicine. She is a Senior Scientist at the Toronto General Hospital Research Institute. Her clinical work at the University Health Network is in mental disorders in the medically ill and women's health. She has also done over 200 MAiD assessments and conducted research and published in medical journals on this topic. She is a member of the Canadian Psychiatric Association Working Group on MAiD, the Canadian Association of MAiD Assessors and Providers, Dying with Dignity and the University of Toronto Centre for Bioethics.

Dr. Stewart graduated as the Gold Medalist in Medicine at Queen's University and practiced as a family doctor in Canada's north before qualifying as a psychiatrist nearly 50 years ago. She held the world's first Chair in Women's Health from 1995–2015. She is a successful medical educator, researcher and clinician and has published over 400 peer-reviewed academic papers and 4 books on medical topics. She is recipient of many awards and in 2014 she became a Member of the Order of Canada. She wrote a Brief and testified at the Senate hearings on MAiD for Mental Illness in February 2021.

CORNELIA (NEL) WIEMAN

Dr. Nel Wieman is the Acting Deputy Chief Medical Officer for the First Nations Health Authority (FNHA) in British Columbia. She is Anishinaabe (Little Grand Rapids First Nation, Manitoba) and lives, works and plays on the unceded territory of the Coast Salish peoples—səl̓ílwətaʔɬ (Tsleil-Waututh), Sḵwx̱wú7mesh (Squamish), and xʷməθkʷəy̓əm (Musqueam) Nations. Dr. Wieman has served as the President of the Indigenous Physicians Association of Canada (IPAC) since 2016.

Dr. Wieman completed her medical degree and psychiatry specialty training at McMaster University. As Canada's first female Indigenous psychiatrist, Dr. Wieman has more than 20 years' clinical experience, working with Indigenous people in both rural/reserve and urban settings. Her previous activities include co-directing an Indigenous health research program in the Dalla Lana School of Public Health at the University of Toronto and the National Network for Indigenous Mental Health Research, being Deputy Chair of Health Canada's Research Ethics Board, and serving on the Canadian Institutes of Health Research's Governing Council. She has also worked and taught in many academic settings, has chaired national advisory groups within Indigenous Services Canada's First Nations and Inuit Health Branch, and has served as a Director on many boards, including the Indspire Foundation and Pacific Blue Cross. She sits on the Executive Committee of the National Consortium on Indigenous Medical Education. She has recently been appointed to the BC Provincial Task Team charged with ensuring implementation of the recommendations arising from the "In Plain Sight" report.

Dr. Wieman holds faculty appointments at Simon Fraser University, the University of British Columbia and McMaster University.

APPENDIX C: SAFEGUARDS, PROTOCOLS AND GUIDANCE RECOMMENDED IN PREVIOUS GOVERNMENT REPORTS

Over the last ten years, a substantial body of work has emerged concerning the subject of assisted dying for persons with mental disorders in the form of academic articles (see for example: Kious & Battin, 2019; Kim, 2021; Blikshavn, Husum & Magelssen, 2017; Verhofstadt, Thienpont, & Peters, 2017; Cholbi, 2013; Dembo, Schuklenk, & Reggler, 2018; Cowley, 2013; Evenblij et al., 2019; Pronk, Willems & van de Vathorst, 2021; Mehlum et al., 2020), reports by health professional associations (AMPQ, 2020), and governmental reports. To illustrate the evolution of advice given to governments about this issue, we provide a summary of recommendations with respect to safeguards, protocols and guidance for persons with mental disorders found in studies mandated or conducted by Canadian governments.

In December 2015, the External Panel on Options for a Legislative Response to *Carter v. Canada* published a report of its consultations in the form of a summary and key findings. This Panel included three experts with complementary disciplinary backgrounds who worked from the time of the *Carter* decision through that calendar year. The report's findings reflect the diversity of views about whether MAiD MI-SUMC should be permitted. Safeguards, protocols and guidance were not the focus of the report, however, there is reference to the position of the Canadian Psychiatric Association (CPA) at that time which recommended psychiatrist involvement for capacity assessments of MAiD requesters with comorbid psychiatric and physical illness, and psychiatric assessments for persons who request MAiD on the basis of a mental disorder (External Panel on Options for a Legislative Response to *Carter v. Canada*, 2015).

The Provincial-Territorial Expert Advisory Group (PTEAG) was an initiative of the Government of Ontario and was supported by 11 Ministries of Health of provinces and territories. British Columbia participated as an observer and Québec did not participate having already adopted its own law on assisted dying in June 2014 (Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, 2015). The PTEAG included nine members with complementary disciplinary backgrounds. Its mandate was to provide non-binding advice to participating provinces and territories in establishing policies and procedures in light of the *Carter* decision. It worked between August and November 2015, prior to Bill C-14 being tabled in Parliament. The report, published in November 2015 considered mental disorders to fall within the expression 'grievous and irremediable medical condition' and did not recommend any safeguards, protocols and guidance specific to this group (Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, 2015).

During the 42nd session of Parliament, a special joint committee of members from the House of Commons and Senate wrote a report entitled: *Medical Assistance in Dying: Patient-Centred Approach*. This work also preceded tabling of C-14. Similar to the PTEAG, this committee considered mental illness to fall within the reach of the *Carter* decision and thus, potentially eligible for MAiD. The recommended safeguards, guidance and protocols applied to all requesters. However, the committee did make a specific recommendation that services and supports (both clinical and social) for persons with mental disorders be improved (Special Joint Committee on Physician-Assisted Dying 2016).

Bill C-14 directed the Minister of Justice and the Minister of Health to initiate three independent reviews relating to MAiD including one concerning MI-SUMC.[50] The federal government asked the Council of Canadian Academies (CCA) to undertake the reviews. The CCA Expert Panel Working Group on MAiD MD-SUMC had 14 members again with complementary disciplinary backgrounds. As required by the law, its report was tabled in Parliament in December 2018. The group's mandate did not include offering recommendations. Instead, as part of its review of the knowledge in this area, it provided an overview of existing safeguards, protocols and guidance internationally, and those proposed in the academic literature (Council of Canadian Academies, 2018).

[50] The three independent reviews related to requests for MAiD by mature minors, to advance requests for MAiD and to requests where mental illness is the sole underlying medical condition.

Finally, in 2021, the government of Québec created a Select Committee of members of the National Assembly to study and make recommendations about access to MAiD for persons with mental illness. This Committee recommended that persons with mental illness be excluded from access to MAiD, and therefore no safeguards, protocols or guidance were discussed (Select Committee on the Evolution of the Act respecting end-of-life care, 2021).

Despite the wealth of material contained within these reports, they contain few recommendations for safeguards, protocols or guidance to serve as a foundation for the Panel's work. However, the Panel did consider safeguards, protocols and guidance in other countries and recommendations made by health professional associations and other organizations.

APPENDIX D: SAFEGUARDS, PROTOCOLS AND GUIDANCE IN COUNTRIES THAT PERMIT MAiD MD-SUMC

Of the countries that permit assisted dying for persons with mental disorders, none have legislated safeguards specific to persons with mental disorders. The Netherlands and Belgium have the most extensive set of safeguards, protocols and guidance overall. These will be presented below.

Luxembourg does not have guidance specific to persons with mental disorders. Switzerland has a minimal legislative framework which is not based on a person having a medical condition. The Swiss practice relies more heavily on protocols developed by civil society assisted dying associations who provide assistance to requesters. These protocols are applicable to all types of requesters. A person is not required to be a physician to provide assistance.[51] However, there has been guidance developed for those physicians who are involved (Swiss Academy for Medical Sciences, 2018). This guidance indicates that, as a result of a Supreme Court decision, a 'detailed psychiatric opinion' is required for requesters with a mental disorder.

The legal situation in Germany is in transition. While assisted suicide itself is not illegal, a recent court decision states that the country's Federal Institute for Drugs and Medical Devices is not obliged to make lethal substances available for the purposes of assisted suicide.[52] There are other methods of obtaining lethal substances and assisted dying associations are providing assistance. To the Panel's knowledge no German protocols or guidance specific to assisted dying for persons with mental disorders has been developed.

The Dutch due care and Belgian eligibility criteria (outlined below) apply to all assisted dying requests. The Belgian law sets out additional safeguards when a patient is not expected to die in the near future (Government of Belgium, 2002).

[51] See: **www.exit-romandie.ch/l-assistance-au-suicide-fr360.html**
[52] See: **www.dw.com/en/german-court-rejects-access-to-euthanasia-medication/a-60639440**

DUTCH DUE CARE CRITERIA

The physician must:

(a) be satisfied that the patient's request is voluntary and well considered;

(b) be satisfied that the patient's suffering is unbearable, with no prospect of improvement;

(c) have informed the patient about his situation and his prognosis;

(d) have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation;

(e) have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;

(f) have exercised due medical care and attention in terminating the patient's life or assisting in his suicide (RTE, 2018).

BELGIAN ELIGIBILITY CRITERIA

The physician must ensure that:

1. the patient has attained the age of majority or is an emancipated minor, and is legally competent and conscious at the moment of making the request;
2. the request is voluntary, well-considered and repeated, and is not the result of any external pressure;
3. the patient is in a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated,resulting from a serious and incurable disorder caused by illness or accident.

If the physician believes the patient is clearly not expected to die in the near future, he/she must also:

1. consult a second physician, who is a psychiatrist or a specialist in the disorder in question, and inform him/her of the reasons for such a consultation. The physician consulted reviews the medical record, examines the patient and must assure himself about the constant and unbearable physical or mental suffering that cannot be alleviated, and of the voluntary, well-considered and repeated character of the euthanasia request. The physician consulted reports on his/her findings. The physician consulted must be independent of the patient as well as of the physician initially consulted. The physician informs the patient about the results of this consultation;
2. allow at least one month between the patient's written request and the act of euthanasia (Government of Belgium, 2002).

While the Dutch and Belgian laws set out the general eligibility criteria and safeguards, the following organizations have developed specific guidance for physicians assessing requests from persons with mental disorders:

- The Dutch Pyschiatric Assocation, Nederlandse Vereniging voor Psychiatrie (NVvP)
- The Dutch Regional Review Committees, Regionale Toetsingscommissies Euthanasie (RTE)
- The Belgian Ordre des médecins
- The Flemish Psychiatric Association, Vlaamse Vereniging voor Psychiatrie (VVP)

The table below summarizes some of the key safeguards, protocols, and guidance in place in the Netherlands and Belgium. Additional recommendations can be found in the documents referenced; the table summarizes the most significant ones.

Safeguards, Protocols and Guidance in the Netherlands and Belgium for Requesters With Mental Disorders

SAFEGUARDS, PROTOCOLS GUIDANCE	NETHERLANDS			BELGIUM		
	Required by law for all requesters	**Recommended by RTE (oversight body) for requesters with mental disorders**	**Recommended by NVvP (Dutch Psychiatric Association)**	**Required by law for all requesters**	**Ordre des médecins (regulatory guidance for requesters with mental disorders)**	**Recommended by VVP for requesters with mental disorders (Flemish Psychiatric Association)**
Discussion about prognosis and therapeutic options	Yes			Yes		
Together with the patient, the physician concludes that there is no reasonable alternative	Yes	If the patient refuses a reasonable alternative, they cannot in principle be said to be suffering with no prospect of improvement. At the same time, patients are not obliged to undergo every conceivable form of treatment.	If the patient refuses a reasonable treatment, and if after discussion the physician does not consider the refusal reasonable, the physician must reject the termination of life request for the time being.	Yes	A patient who refuses evidence-based treatments that are likely to relieve suffering cannot be considered to be incurable and, therefore, the practitioner cannot provide euthanasia.	If a person refuses a treatment offering a reasonable prospect of success, the person does not have an incurable condition.

SAFEGUARDS, PROTOCOLS GUIDANCE	NETHERLANDS			BELGIUM		
	Required by law for all requesters	**Recommended by RTE (oversight body) for requesters with mental disorders**	**Recommended by NVvP (Dutch Psychiatric Association)**	**Required by law for all requesters**	**Ordre des médecins (regulatory guidance for requesters with mental disorders)**	**Recommended by VVP for requesters with mental disorders (Flemish Psychiatric Association)**
Time requirements	None required		The assessment process can be lengthy and requesters should be informed of this.	Yes **If the person's death is not foreseeable there must be** at least one month from the person's written request and euthanasia. First assessment must take place during several conversations over a reasonable period of time.	A lengthy period of clinical follow-up is required to ensure the request is durable.	The assessment process can be lengthy and requesters should be informed of this.
Discussion with other clinicians involved in the person's care	Not required		Discussions with other clinicians involved including psychiatrists who saw the requester in the past are recommended.	Yes Discussion with the nursing team.		Discussion with other clinicians involved including key practitioners from the past is recommended. Refusal by the person to permit contact with previous clinicians may result in a refusal of the request.
Discussion with the person's family or significant others (with consent)	Not required		Recommended except in exceptional circumstances.	Yes if the requester wishes.		Discussion with family and/or significant others is recommended. The patient's refusal to have third parties involved may, however, result in the doctors involved being unable to perform their tasks properly, and may result in a refusal of the request.

SAFEGUARDS, PROTOCOLS GUIDANCE	NETHERLANDS			BELGIUM		
	Required by law for all requesters	**Recommended by RTE (oversight body) for requesters with mental disorders**	**Recommended by NVvP (Dutch Psychiatric Association)**	**Required by law for all requesters**	**Ordre des médecins (regulatory guidance for requesters with mental disorders)**	**Recommended by VVP for requesters with mental disorders (Flemish Psychiatric Association)**
Eligibility assessment by an independent consulting physician	Yes Advice is non-binding.	An independent psychiatrist should assess past treatments and make treatment recommendations where appropriate. This requirement means that in most cases three physicians participate in the assessment. However, the independent psychiatric assessment and independent assessment of eligibility can be undertaken by a single individual (e.g., an independent psychiatrist) if three assessments would be too burdensome for the requester.	Psychiatrist is recommended as the 2nd assessor if the 1st assessor is not a psychiatrist.	Yes Advice is non-binding.	Independent consulting physician should be a psychiatrist.	All three physicians should comment on eligibility not just the two who are legally required to do so. Two of the three physicians involved should be psychiatrists. Two of the three must agree to accept the request.
Consultation with an independent physician with expertise in the disorder causing suffering	Not required		Independent psychiatrist to make treatment recommendations where appropriate.	**If the person's death is not foreseeable** the independent physicians with expertise should be a psychiatrist or specialist in the disorder that is motivating the request. Advice is non-binding. This requirement means that, in these cases, three physicians participate in the assessment.	Independent physician with expertise should be a psychiatrist. The three physicians should arrive at a shared conclusion.	
EAS deaths must be reported to an oversight committee	Yes			Yes		

Sources: Government of the Netherlands, 2002; Government of Belgium, 2002; NVvP, 2018; RTE, 2018; VVP, 2017; Ordre des médecins, 2019

APPENDIX E: SAFEGUARDS, PROTOCOLS AND GUIDANCE FOR MAiD MD-SUMC RECOMMENDED BY CANADIAN ORGANIZATIONS AND GROUPS

The following table summarizes some of the key safeguards, protocols, and guidance for MAiD MD-SUMC recommended by Canadian organizations and groups. The Association des médecins psychiatres du Québec, the Canadian Psychiatric Association and the Canadian Bar Association are professional associations. The Halifax Group is a group of academics. Additional recommendations can be found in the documents referenced, the table summarizes the most significant ones.

PROPOSAL	HALIFAX GROUP (2020)	ASSOCIATION DE MÉDECINS PSYCHIATRES DU QUÉBEC (2020)	CANADIAN PSYCHIATRIC ASSOCIATION (2022)	CANADIAN BAR ASSOCIATION (2022)[53]
Non-ambivalence[54,55]	Not recommended	Not addressed	Not addressed	Not recommended; does not believe this concept is relevant to the *Criminal Code*.
Well-considered	A MAiD request should be well-considered and this requirement should be introduced as a new eligibility criterion. This does not require an evaluation of the quality of the decision but rather an assessment of the decision-making process to ensure that it is well thought out and not impulsive.	Assessors should consider whether emotional reactions, interpersonal dynamics, and values arising from the disorder are having a negative impact on the individual's ability to consider options and make judgments.	a) Requests should be considered and sustained and not result from a transient or impulsive wish especially in the case where a mental disorder is episodic in nature. b) Both acute and chronic suicidal ideation must be considered and evaluated to make a best determination as to whether the request represents a realistic appraisal of their situation rather than a potentially treatable symptom of their mental illness.	Not recommended; does not believe this concept is relevant to the *Criminal Code*.
Minimum duration of medical condition	Not specified but something to consider in assessing requests.	Not specified but recognizes that chronicity of the person's condition is important to consider.	Not specified but consideration must be given to the length of time since diagnosis.	Establishing a specific time requirement may be arbitrary.
Incurability/ irreversibility	Exploration of available alternatives to MAiD with particular attention to mental health services and social supports.	Biopsychosocial treatment history and chronicity need to be taken into consideration. The possibility of improvement with treatment in the foreseeable future should also be considered while balancing benefits and harms.	Documentation should demonstrate that standard treatments, including pharmacological, psychotherapeutic and non-pharmacological therapies for the specific mental disorder as well as social/environmental supports, have been offered, attempted and failed over a sufficient period of time and that there are no other accessible reasonable alternatives.	Suggests that a person should be presented with reasonable therapeutic options (whether these involve medication or psychotherapy) prior to being deemed eligible.
Capacity	No specific changes to capacity assessment are recommended.	Capacity should be assessed longitudinally and should take into consideration other factors beyond the legal criteria.	No specific changes to capacity assessment are recommended. Attention should be given to recurrent suicidality.	No specific changes to capacity assessment are recommended. Attention must be given to suicidality.

[53] The Canadian Bar Association also states the following: Parliament may consider whether assessment should be longitudinal and not based on a single meeting with the patient. This recommendation refers to MAiD eligibility assessments.

[54] The idea that a person requesting MAiD be "non-ambivalent" was mentioned by the trial judge in the *Carter* decision (SCC, 2015, para 29).

[55] A group of academics and collaborators, the Expert Advisory Group, recommended that 'a non-ambivalence criterion should be required for MAiD in situations where death is not reasonably foreseeable.' However, this recommendation does not apply to MAiD MD-SUMC because the group also recommended that MAiD MD-SUMC not be permitted (Expert Advisory Group on Medical Assistance in Dying, 2020).

PROPOSAL	HALIFAX GROUP (2020)	ASSOCIATION DE MÉDECINS PSYCHIATRES DU QUÉBEC (2020)	CANADIAN PSYCHIATRIC ASSOCIATION (2022)	CANADIAN BAR ASSOCIATION (2022)[53]
Psychiatric consultation	At least one assessor be someone with expertise in the condition or consult with someone who has expertise in the condition.	Psychiatrists should be involved as both the first and second assessors and should be independent from each other.	At least one independent psychiatrist with expertise in the mental disorder should be one of the eligibility assessors. At least one independent psychiatrist who has expertise in the mental disorder should complete a comprehensive clinical assessment to validate whether the patient has received an accurate diagnosis and if they have had access to evidence-based mental health assessment, treatment and supports for an adequate period of time based on generally accepted standards of care.	Parliament may consider specifying that the "expert" (outlined in Section 241.2(3.1)(e.1) of the *Criminal Code*) must be a psychiatrist or another mental illness specialist.
Multi-disciplinary perspective	Assessors should seek out the perspective of other professionals involved in the requester's care.	Assessors should seek out the perspective of clinicians involved in the requester's care (e.g., psychiatrist—if not already involved in the assessment, psychologists, social workers, etc.).	The assessment process should involve gathering the perspective of the multidisciplinary team about the patient's illness and course of treatment.	Multi-disciplinary teams exploring the dynamic between patients, their community and health care team might be useful. Associated guidelines should be developed by provinces and territories and relevant professional regulators.
Collateral history	Recommends a review of a person's social context through discussion with friends, relatives and carers.	Assessors should meet with the requester's significant others unless this is contraindicated or refused. Assessors should obtain reports from earlier MAiD requests with the requester's consent.	The assessor should communicate with the patient's current and past clinicians, and the patient's family and/or friends. Assessors should have access to previous MAiD assessments with the person's consent.	Not specified
Task-specific training of assessors	Recommended	Recommended	Recommended	Not addressed

PROPOSAL	HALIFAX GROUP (2020)	ASSOCIATION DE MÉDECINS PSYCHIATRES DU QUÉBEC (2020)	CANADIAN PSYCHIATRIC ASSOCIATION (2022)	CANADIAN BAR ASSOCIATION (2022)[53]
Oversight	Not addressed	A new provincial clinical-administrative entity, the Bureau régional d'AMM lors d'un problème de santé mentale (BRAMM-SM) should be created. Its role is to provide prospective oversight.	A prospective review process at the federal level should be established for MD-SUMC requests for an initial period of time (e.g., two to five years). This could be followed by retrospective oversight at the provincial level.	Not addressed
Case review	A *post hoc* peer review process should be established for an initial five-year period for all requests outside Québec for MAiD in circumstances in which the person did not have a diagnosis of a lethal condition.	The BRAMM-SM would provide formative feedback to assessors with the goals of improving the quality of care and decision-making.	Not addressed	Not addressed

Sources: Halifax Group, 2020; AMPQ, 2020; CPA, 2022 & Canadian Bar Association, 2022

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MAiD AND MENTAL ILLNESS