A Brief Submitted to
the Special Joint Committee on Medical Assistance in Dying

Regarding Follow-up on Recommendation 13 of the Second Report of the
Special Joint Committee on Medical Assistance in Dying on
Preparedness for MAID for Mental Disorders as a Sole Underlying Medical Condition
(MAID MD-SUMC)

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***The view expressed in this brief are entirely my own. They do not express the views or policies of the NIH or any other part of the US government.**

I am a psychiatrist and a bioethicist who conducts research on the ethical, clinical, and legal aspects of MAID for persons with psychiatric disorders. I served on the Council of Canadian Academies Expert Panel Working Group on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition, and served as an expert witness in *Truchon vs Canada*. In this brief, I provide evidence-based answers to some key questions that the Committee may find useful.

What is the potential number of cases of MAID MD-SUMC in Canada if it is legalized?

Some MAID providers have been telling lawmakers that the number of people seeking MAID for mental illness will be small, but this is not based on evidence. Here are instead some evidence-informed estimates.

About 5 to 10 per cent of requests for psychiatric MAID are granted in the Netherlands. In 2022, there were 115 cases of psychiatric MAID in the Netherlands; thus, about 1150 to 2300 requests were made. This is equivalent to about 2500 to 5000 likely requests in Canada.

But the number of requests and granted requests of psychiatric MAID—once the legalization is fully implemented across the country—will likely be much higher in Canada, for several reasons.

One, the reason for the low 5-10% approval rate is that the Dutch law requires that MAID can only be a last resort. But in Canada, irremediability is determined by the subjective preference of the patient (in the case of psychiatric MAID, patients whose subjective outlook is darkly colored by their illness). Based on published data regarding the most common reason for non-approval in the Netherlands, I estimate that the approval rate in Canada could be 50% or higher, or 1250 to 2500 cases of MAID SUMC per year… assuming that the request rate will be similar to the Netherlands.

But the rate of psychiatric MAID requests in Canada will likely be higher than in the Netherlands. Keep in mind that, as my team's studies of Dutch psychiatric MAID cases have shown, people who request psychiatric MAID and people who attempt and die by suicide have very similar clinical profiles. Although about 4,500 Canadians end their own lives every year, probably about 20 times that number attempt to end their lives, and with an even greater number who wish for death without taking action; most have some form of mental illness. Keep in mind also that MAID is 100% lethal.

In Canada, in contrast to the Netherlands, for many such people in need, the health care system fails to cover even basic elements of mental health care, such as psychotherapy and prescription medications, much less adequate disability supports. In over 200 Dutch MAID case reports that I have read, I cannot recall any patient being forced to seek MAID due to lack of standard resources. But in Canada, even the government's own website acknowledges that this must happen under its current law.

Thus, the number of cases of MAID SUMC will not be small. Any claim to the contrary is not based on evidence.

What aspects of MAID MD-SUMC are particularly worrisome?

Women seek and receive psychiatric MAID at approximately 2-3 times the rate of men because they have higher incidence of conditions and experiences that put them at risk of suicide, such as depression, personality disorders, and history of trauma. The structural inequality of mental health resources in Canada will result in women disproportionately dying by MAID instead of receiving the needed help.

It is thus rather chilling that a psychiatrist testifying to this committee, and who has been central in advising the government on MAID MD-SUMC policy, responded regarding this gender ratio that "it doesn't concern me, in the sense that nobody knows what it means."

We also know, from a Belgian study of 100 consecutive patients referred for psychiatric MAID evaluation, that the desire for the procedure can be highly unstable; even when psychiatric suffering was deemed by a psychiatrist to be "chronic, constant and unbearable, without prospect of improvement," the majority of requestors changed their minds, eventually "managing with regular, occasional or no therapy." I am not aware of any government safeguard proposal that even attempts to address this obvious problem of false positives—i.e., intentionally terminating lives of young people who would have regained their perspective on life.

Finally, my team's systematic review of the literature found that doctors are not very good at predicting whether even patients labeled as having "treatment resistant" depression will in fact not respond to future treatments. Majority of depressed persons with clinical profiles similar to persons seeking and receiving psychiatric MAID in the Netherlands in fact achieve remission. And we lack tools to predict who will and will not go into remission. I would emphasize to the committee that anyone who claims that they can make reliable determinations of irremediable depression is not doing so on the basis of scientific evidence.

Are their safeguards in place in Canada to mitigate these special risks in MAID SUMC?

The government of Canada and its advisors have not proposed specific measures to mitigate the risks outlined above. Instead, and alarmingly, they have asserted that MAID MD-SUMC is 'complex just like other cases of MAID' and have specifically argued against special safeguards for MAID MD-SUMC.

Such an argument obscures the evidence-based clinical realities, using a superficial appeal to 'equality.' If the past is any indication, the Committee will receive many ideologically driven, artful opinions like this during these hearings.

It is unfortunate that the trajectory of Canadian MAID policy has been so disturbingly ideology driven. But it does not have to be. Good faith, evidence-based debate is possible on this controversial topic (see recent examples in Denmark or the Island of Jersey). Not only Canada's international reputation, but more importantly the lives of many vulnerable Canadians—with painful lived experience of inadequately addressed mental disorders and whose safety and well-being are now threatened by a reckless MAID policy—depend on it.

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