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Canadian Psychiatric Association
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Written Brief to the Special Joint Committee on Medical Assistance in Dying
May 9, 2022

The Canadian Psychiatric Association (CPA) would like to provide information for the committee to consider as it completes its statutory review of the provisions of the Criminal Code with respect to medical assistance in dying (MAiD) and their application.

In response to Bill C-7, the pending expiry of the prohibition on MAiD in the context of mental disorders alone, and input received during the most recent consultation process, the CPA published a discussion paper in August 2021 as well as an updated position statement in October 2021. The discussion paper was a means to obtain further input from members and from more than 60 stakeholder organizations who were invited to comment.

Comments and recommendations received are summarized in detail in the results of the CPA's discussion paper consultation. While some psychiatrist respondents remain opposed to any access to MAiD for persons whose sole underlying medical condition is a mental disorder (MD-SUMC), based on the majority of feedback received, the discussion paper reflects the primary areas of concern for psychiatrists.

As outlined in the discussion paper and detailed in the consultation report, additional safeguards that should be considered when determining eligibility for MAiD for MD-SUMC include:

- **Comprehensive clinical assessment of mental disorder**: Separate from any MAiD eligibility assessment, it is essential that at least one independent psychiatrist who has expertise in the mental disorder in question completes 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.

- **Robust eligibility assessment process**: It is essential that at least one independent psychiatrist with expertise in the mental disorder be one of the eligibility assessors of a patient who wants to be considered for MAiD on the basis of MD-SUMC.

  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.

  There is a lack of consensus in psychiatry about a generally agreed upon definition of incurability. Comments received in response to the discussion paper highlighted the high level of concern about the ability to definitively determine that a mental illness is “irremediable,” given the lack of scientific evidence in this area. Other comments reflected the need to assess “irremediability” within the clinical and scientific parameters that exist at the time of the request, versus considering the request in the context of potential interventions that might evolve in the future. The importance of considering socioeconomic determinants of health, which play a key role in each person’s experience of illness and suffering and adaptability to mental illness, was also emphasized. If a patient refuses recommended treatment for their disorder without good reason, weighing both the potential benefits and burdens, they are unlikely to have met the eligibility criterion for incurable.

  With respect to capacity, physicians are already assessing and providing MAiD for patients with a concomitant mental illness but whose request for MAiD is based on another medical condition. Some respondents queried whether the *Starson* criteria were sufficient in the context of an intervention that causes death. Others were concerned about the potential for people requesting MAiD for MD-SUMC being held to a higher standard based solely on their diagnosis, which may not be sufficient to address the legislative objective of balancing patient autonomy with protecting vulnerable persons.

  Both acute and chronic suicidal ideation must be considered and evaluated to make a best determination as to whether the patient’s wish to end their suffering represents a realistic appraisal of their situation rather than a potentially treatable symptom of their mental illness. The difficulty of separating out suicidal patients, particularly in patient populations where recurrent suicidality is a feature, was also mentioned as being of particular importance while assessing capacity.

The assessment process should be trauma-informed and should gather multiple perspectives on the patient's illness and course of treatment. A comprehensive eligibility assessment process must allow for ongoing necessary and potentially serial assessment and evaluation with the patient, their current and past psychiatrists/clinicians, multidisciplinary team members, and—with the patient's prior consent—the patient's family and/or friends.

- **Durability and voluntariness of the request**: 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. Consideration should be given to the nature of the mental disorder, the length of time since diagnosis, and whether the patient has been considering MAiD for some time.

  Experiences and perceptions of stigma, vulnerability, and of being a burden to society have the potential to influence a person's decision to request MAiD in both mental and physical illness. A number of submissions CPA received expressed concern that societal pressures might increase a person's sense that MAiD is the solution that others might be hoping they will take.

  It was that while the legal benchmark for assessing the durability of the request has been set at 90 days for Track 2, this may not necessarily be the optimal time frame for those with MD-SUMC, and nothing in the law would prevent assessors from recommending a longer period.

- **Effective and timely oversight process**: Alongside an oversight process, it is important to establish a coinciding research agenda for evaluation purposes and to modify policies and practices in relation to safeguards as needed. It has been suggested that, as an added layer of protection for patients with MD-SUMC and for consistency, the oversight process be standardized across provinces. A prospective review process at the federal level of MD-SUMC requests for an initial period of time (e.g., two to five years) could allow for concerns or issues to be identified and addressed before a move to retrospective reviews at the provincial level.