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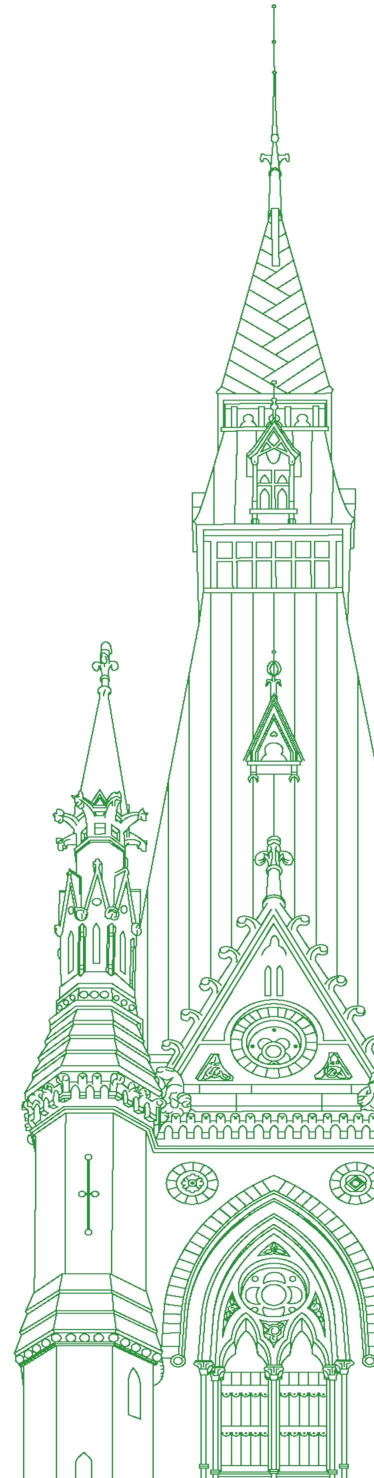

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The Honourable Marc GarneauThe Honourable Yonah Martin

Special Joint Committee on Medical Assistance in Dying

Wednesday, May 25, 2022

● (1435)

[*English*]

The Joint Chair (Hon. Yonah Martin, Senator, British Columbia, C): I call this meeting to order.

[*Translation*]

Hello, everyone.

[*English*]

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

I'd like to begin by welcoming the members of the committee, the witnesses and those watching this meeting on the web. I'm Senator Yonah Martin, and I'm the Senate joint chair of this committee. I'm joined by the Honourable Marc Garneau, the House of Commons joint chair.

Today we're continuing our examination of the statutory review of the provisions of the Criminal Code relating to medical assistance in dying and their application.

The Board of Internal Economy requires that committees adhere to the health protocols that are in effect until June 23, 2022. As joint chairs, we will enforce these measures. We thank you for your co-operation.

I'd like to remind members and witnesses to keep their microphones muted unless recognized by name by a joint chair. I would remind you that all comments should be addressed through a joint chair. When speaking, please speak slowly and clearly. Interpretation in this video conference will work like an in-person committee meeting. You have the choice at the bottom of your screen of floor, English or French audio.

With that, I'd like to welcome, on behalf of our committee, our witnesses for panel one. They are here to discuss whether to permit medical assistance in dying for mental illness in Canada.

In this panel we have, as individuals, Brian Mishara, professor and director, Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices, Université du Québec à Montréal; and Dr. Derryck Smith, clinical professor emeritus, department of psychiatry, University of British Columbia. We also have Mr. David E. Roberge, member, end of life working group, the Canadian Bar Association.

Thank you, witnesses, for joining us today. We'll begin with opening remarks from Dr. Mishara, followed by Dr. Smith and Mr. Roberge.

Dr. Mishara, you have five minutes. The floor is yours.

Professor Brian Mishara (Professor and Director, Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices (CRISE), Université du Québec à Montréal, As an Individual): Thank you.

For 50 years I've been conducting research on suicide prevention and end-of-life issues and working in suicide prevention. In 1995 I held the Bora Laskin national fellowship in human rights research to study euthanasia in the Netherlands. I have published 12 books and over 180 scientific papers.

We live in a country where our laws and culture emphasize respect for autonomous choice. However, society does impose limits to protect us from making decisions that are dangerous to ourselves. We are legally obliged to wear a helmet on a motorcycle, a seat belt in a car and a hard hat at a construction site. Our government acts to protect competent people from making decisions that may endanger their health and well-being, whether they like it or not. We must protect people from making irreversible decisions to die when there is hope for recovery.

I believe suffering from a mental illness may be as intense as suffering from a physical illness. The key issue is whether it is possible to determine if suffering from a mental illness is interminable and irremediable. The expert panel report on MAID and mental illness states that there are no specific criteria for knowing that a mental illness is irremediable, and they do not provide one iota of evidence that anyone can reliably determine if an individual suffering from a mental illness will not improve.

According to research, 50% to 60% of persons with depression or anxiety will recover without any treatment. Even the most severe mental illnesses, such as schizophrenia, are unpredictable: 50% of people with schizophrenia meet objective criteria for recovery for significant periods during their lives.

If it were possible to distinguish the very few people with a mental illness who are destined to suffer interminably from those whose suffering is treatable, it would be inhumane to deny MAID. But any attempt at identifying who should have access to MAID will make large numbers of mistakes, and people who would have experienced improvements in their symptoms and no longer wish to die will die by MAID.

Throughout the western world, it has been statutory and customary practice to protect suicidal persons from dying. Almost all high-risk suicidal persons I have talked with would meet the current requirements for MAID. Over 90% of people who die by suicide have a diagnosable mental disorder. They usually have had many years of mental health treatments, and they are convinced that their suffering is intolerable, inevitable and interminable. They are almost always wrong in their assessment. Even in extreme cases where a person is taken to hospital unwillingly, only 10% will attempt again, and only 1% to 3% will die. The vast majority are happy to have been saved and are usually very thankful to be alive.

For every heart-wrenching story of someone who suffered interminably from a mental illness, there are so many more people who got help and were happy to be alive. If MAID for people with mental illness becomes legal next year, a large proportion of suicidal people could be dead instead of getting the help they need.

Canada already has the most liberal access to MAID in the world. Elsewhere, all people who receive MAID are denied their request if there are other treatments available to alleviate physical and mental suffering. Both the physician and patient must agree that there is no reasonable alternative. In Canada the physician must inform patients of potential treatments, but if the patients don't feel they are acceptable, medical professionals are still obliged to end their lives.

In the Netherlands no one is forced to try the treatments, but the doctors are not allowed to end people's lives if they believe their suffering may be alleviated by other means. In the Netherlands only 5% of requests for MAID for a mental disorder are granted. After receiving an average of 10 months of psychiatric evaluations, almost all requests are refused, usually because untried treatments are available.

● (1440)

Even in medical cases of terminal illness, 40% of requests are refused because the doctor believes there is some untried treatment for the suffering, and hardly any of those who are refused repeat their request after trying the treatments. The expert panel's report ignored the research showing that a large proportion of people feeling utterly hopeless with a mental disorder will improve over time. It provides no evidence indicating that anyone can tell if a mental illness is incurable, irreversible and enduring, because the research indicates this is currently not knowable.

I have personally known—

The Joint Chair (Hon. Yonah Martin): Thank you, Dr. Mishara. Five minutes have passed.

Prof. Brian Mishara: —hundreds of thousands of people who have convincingly explained that they wanted to die to end their suffering and are now thankful to be alive. If you proceed to allow MAID for persons with a mental illness, how many people who would later have been happy to be alive are you willing to allow to die?

The Joint Chair (Hon. Yonah Martin): Thank you very much, Dr. Mishara.

Next we will have Dr. Smith for five minutes.

Dr. Derryck Smith (Clinical Professor Emeritus, Department of Psychiatry, University of British Columbia, As an Individual): My name is Derryck Smith. I am a practising psychiatrist. I was head of children's and women's psychiatry in Vancouver for 30 years, and I have been personally involved in two cases involving psychiatric illness and MAID, both of whom have received MAID, incidentally.

You've heard a [*Technical difficulty—Editor*].

The Joint Chair (Hon. Yonah Martin): I'm sorry, Dr. Smith, but your sound is going in and out. We're only catching a few of your words. I wonder if there is a technical issue.

Dr. Derryck Smith: I don't know. I'll try again.

The Joint Chair (Hon. Yonah Martin): Would you continue? Thank you.

Dr. Derryck Smith: I'm talking about the reliability of psychiatric diagnoses. There's good research that shows that psychiatric diagnoses are as reliable as other medical diagnoses. This is in spite of the fact that we don't have biological markers like blood tests or X-rays to make psychiatric diagnoses. The reason for that is that the brain's a very complicated organ and we don't understand it.

However, the courts have certainly relied on psychiatric diagnoses over many years. In fact, the Truchon case in Quebec, which ended up with Bill C-7 being introduced, relied extensively on psychiatric diagnosis. The madam justice found that a psychiatrist can make accurate diagnoses.

In my opening statements—which you have—I've included a table showing that, compared to other medical diagnoses, psychiatric diagnoses are just as reliable.

The second thing I want to talk about is whether psychiatric illness is irremediable. Mental illness usually isn't a terminal illness, unless you're looking at conditions like Alzheimer's. Under current law, one does not have to have a terminal illness as a requirement for MAID.

I think it's instructive to look at the case of A.B. from Ontario, where a judge granted MAID for a woman who had osteoarthritis. This is not a condition that is terminal or usually results in death. The judge agreed to providing MAID for A.B. because she looked at the whole person. One cannot look just at a diagnosis. You have to understand the nature of the human experience of the person who's sitting in front of you. Don't rely entirely on what the diagnosis is. It's the person that we're interested in here.

In a more recent decision, Justice Baudouin granted Jean Truchon, a disabled man, his request for MAID. In the judgment—which I'm sure you've had—on paragraph 466 it says, “The physicians involved are able to distinguish a suicidal patient from a patient seeking medical assistance in dying.” That was one of her conclusions.

Unlike the previous witness, I think, when it's tried in a court of law, the judge has accepted that psychiatrists can distinguish between suicidal thinking and people who are seeking MAID. I'm in agreement with that.

Now, “irremediable” is a term that's used when there are no more treatments available that are “acceptable” to the patient. Under law, the patient cannot be forced to take any types of treatments that are available. They must agree. If a person refuses additional treatment, I would, therefore, consider them to be irremediable. One of the major controversies in psychiatry is whether people with depression should be forced to have electroconvulsive therapy. I think the law is quite clear. The patient must agree. If they don't agree and there are no other treatments available, then the person has an irremediable condition.

We're not talking here about people who have been depressed for a day or have had six months of distress. We're talking about people who have been psychiatrically ill for years and have tried many different treatments—medication, psychotherapy and so on. All of the cases you've heard quoted from the Netherlands are chronic patients with many years of treatment.

The next thing I want to speak about is whether the vulnerable need protection. Again, this has been tried in court with both the Carter case and Truchon case. There is no evidence that vulnerable people are at risk for MAID. In fact, if you look at the actual people who are receiving MAID, they are typically white, well educated and well off. You could easily argue that the marginalized communities are disadvantaged because they're not accessing MAID. In the Truchon case, Justice Baudouin equally found that the disadvantaged are not being taken advantage of and you must do each case at a time.

I thought I would talk to you about the two cases I've been involved with.

One was a woman, E.F. This was extensively reviewed by Madam Justice Baudouin in her judgment. E.F. was a woman with a conversion disorder. She had the condition for about 10 years. It's a complicated psychiatric neurological condition. In the end, a justice in the Queen's Bench granted her MAID. The Attorney General of Canada appealed it and the court of appeal granted it based entirely on the psychiatric diagnosis.

That was before Bill C-14, when the rules flowed out of the Carter decision. We know from Carter that psychiatric illness was not an exclusion.

● (1445)

If you look carefully at Bill C-14, there is nothing that excludes psychiatric patients. Again, this was a finding from Madam Justice Baudouin in the Truchon case.

I, personally, was involved with a woman who was in her forties. She'd had an eating disorder for many years. She'd had every known treatment. The family was richly resourced. She'd been to treatment centres in the United States. I interviewed her and her father, who was a retired Supreme Court justice. Her father said knowingly that he understood the situation and it broke his heart to agree with his daughter that she needed an assisted death. In the end, it was his opinion that she should have an assisted death. After a full assessment program, she did have an assisted death. Those are the only two patients that I've been personally involved with.

The numbers across Canada up to this point are enormously small and they will, incidentally, continue to be small as well. If we look at the Benelux countries, there are very few patients who actually get approved for psychiatric illness leading to MAID, so we don't have to worry about a tsunami of psychiatric patients lining up, applying for MAID and being approved for that.

● (1450)

The Joint Chair (Hon. Yonah Martin): Thank you very much, Dr. Smith.

Lastly, we'll have Mr. Roberge for five minutes.

Mr. David E. Roberge (Member, End of Life Working Group, The Canadian Bar Association): Good afternoon, Chairs and honourable members of the committee.

My name is David Roberge, and I am a member of the end of life working group of the Canadian Bar Association.

On behalf of the CBA, thank you for the opportunity to address this committee.

[*Translation*]

The Canadian Bar Association, or CBA, is a national association of 36,000 legal specialists from across the country. The CBA end-of-life working group comprises a cross-section of members from diverse areas of expertise, including constitutional and human rights law, criminal justice, and health law.

The CBA has demonstrated an abiding commitment to clarifying the law about end-of-life decision-making and stressing the importance of a pan-Canadian approach consistent with the criterial established by the Supreme Court of Canada in Carter.

[*English*]

We acknowledge that medical assistance in dying is complex and raises important issues and diverse views. This is perhaps even more so in cases of mental illness. The CBA recognizes the importance of appropriate health care and social support for people living with mental illness. Meanwhile, we must realize that the suffering of these individuals is no less real than those of individuals with physical illnesses.

As such, the framework should recognize the rights of persons with mental illness to make their own health care decisions, including MAID, in a manner that balances autonomy and appropriate safeguards.

In a nutshell, the CBA's position regarding the issue of MAID and mental illness as the sole underlying medical condition is as follows.

Firstly, Parliament should authorize MAID in some cases of mental illness pursuant to a patient-centric approach and provided appropriate safeguards are in place.

[*Translation*]

Secondly, Parliament must ensure that any additional safeguards, whether they relate to the expertise of the assessor, timelines, or informed consent, do not unduly prolong the suffering of patients would otherwise be eligible for MAID.

[*English*]

Thirdly, Parliament should ensure that in cases of mental illness, MAID aligns with current best practices in mental health care.

While some issues pertaining to MAID and mental illness would be more appropriately addressed by medical experts, the CBA wishes to highlight key considerations on the topic of appropriate safeguards from a legal perspective.

[*Translation*]

As to the scope of the law, Parliament must clearly define the scope of MAID in the case of mental illness to avoid any ambiguity on the applicable protocols and safeguards.

As to the assessor's expertise, in view of the inherent complexity of mental illnesses, Parliament might wish to require that one of the MAID assessors be a psychiatrist. Access to those specialists in practice must also be considered, because any delays could unduly prolong the patient's suffering.

[*English*]

Regarding time limits, currently, for situations where natural death is not foreseeable, at least 90 days must elapse between the initial request and the administration of MAID. An appropriate period is required to enable MAID assessors to conduct a full review of the patient's circumstances. Parliament must be mindful of the risk of arbitrariness in setting time limits, irrespective of the nature of the mental disorder.

[*Translation*]

Turning to informed consent, the patient requesting MAID must have been offered reasonable therapeutic solutions in order to make an informed choice. The opportunity to strengthen informed consent criteria is the subject of debate. In this regard, the CBA maintains that consideration must be given to the health care standards guidelines of provincial governments and professional regulatory bodies.

● (1455)

[*English*]

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Roberge and all of our witnesses.

We will go into our first round. Each member will have five minutes.

First, it's Mr. Cooper.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Thank you, Madam Chair.

Thank you to the witnesses. I'm going to direct my questions to Dr. Mishara.

Dr. Mishara, the final report of the expert panel concluded that, on the question of irremediability in the case of mental illness, that can be reasonably satisfied based on the evolution and response of the patient to past interventions and treatments. In other words, if treatments and interventions haven't worked and haven't made them better over a period of time, that would suffice to satisfy the requirement of irremediability.

I'd be curious as to your thoughts. That was also stated by Dr. Smith.

Prof. Brian Mishara: I believe that Dr. Smith confuses irremediability of the diagnosis and the reliability of giving a diagnosis with the question of irremediability of the symptoms that lead to a request for MAID. Yes, you can reliably determine that someone has schizophrenia or suffers from depression, but the vast majority of people with those mental illnesses will not seriously consider suicide, request MAID or have severe, untreated symptoms that lead them to want to die.

I'm a scientist. The latest Cochrane Review of research on the ability to find some indicator of the future course of a mental illness, either treated or untreated, concluded that we have no specific scientific ways of doing this. We are relying on the clinical hunch of someone who hasn't known the person for 20 or 30 years and who has no scientific data showing that they can determine this.

I accept that many mental illnesses are not remediable, but that doesn't mean that a person with proper treatment will not have a good and full life, despite the fact of having a mental illness. The real issue is that, in suicide prevention, every single person who calls a crisis line meets the MAID criteria. They are suffering. They feel it's interminable, and they often have refused treatment.

The difference between Canada and every other country in the world is that elsewhere in the world, if the physicians feel there is a treatment, the person doesn't have to do the treatment. It's up to them, but they don't kill them.

Mr. Michael Cooper: I'm sorry to interrupt. I want to allow you to pick up on that point, because Dr. Smith said that, in the case of the Benelux countries, a very small number of persons who access MAID suffer from a sole underlying mental illness condition. Hence, there's nothing to worry about. I think that ties in with what you were going to say.

Prof. Brian Mishara: The number who are accepted is fairly small. In 2016, in the Netherlands, it was about 1,500 people who requested it. They have a very detailed protocol, which takes an average of 10 months of assessments and evaluation. Of those almost 1,500, they accepted 60 of those cases after spending more time with the patients than most mental patients receive in psychotherapy in Canada over the course of 10 or 15 years. The number who request it is fairly substantial.

In those countries, the number that are accepted is low because they have this criteria and they believe there is some treatment. Whether the person wants it or not is their choice, but they feel that the state is not obliged to end the lives of people who can be treated.

● (1500)

Mr. Michael Cooper: Right, and—

The Joint Chair (Hon. Yonah Martin): There are about 10 seconds left, Mr. Cooper.

Mr. Michael Cooper: My time, Madam Chair, has therefore expired.

The Joint Chair (Hon. Yonah Martin): Thank you.

Next, we will have Mr. Arseneault for five minutes.

[*Translation*]

Mr. René Arseneault (Madawaska—Restigouche, Lib.): Thank you, Madam Chair.

I would like to thank the witnesses for their valuable contributions.

My first question is for Dr. Smith.

Dr. Smith, it is reassuring to hear that psychiatrists are able to distinguish between the two main categories of individuals with mental health problems, namely, those who are suicidal and those seeking medical assistance in dying.

Can you tell us more about how psychiatrists go about making the distinction between a suicidal person and a person with mental health issues who is seeking medical assistance in dying?

[*English*]

Dr. Derryck Smith: Thank you, Mr. Arseneault, for that question. I'm sorry I cannot answer you in French. I'll do my best in English.

I think the detailed answer is in this report, which you have received already, the report of the expert panel on MAID and mental illness. I'm not going to be able to go over that in five minutes, but I want to reassure you again, as I mentioned previously, that in court this has been tried, not with a bunch of opinions but with cross-examination demanding hard evidence.

The hard evidence in the Truchon case was that there is a vigorous and strict process in place for MAID in Canada that has no problems with that. Second, physicians are able to distinguish between a suicidal patient and a patient seeking medical assistance in dying. Those are established facts from the courts.

We have no difficulty making these facts known when we are in court because there you must not just have opinions; you must have facts, and the facts can be tried. There can be cross-examination and new evidence for jurors.

I want to assure you that as a practising psychiatrist, we see people who have suicidal thinking all the time. It's part and parcel of psychiatry. I personally have no problems separating a patient who is having suicidal ideation from a person who is seeking MAID. For one thing, the person seeking MAID has probably been suffering with psychiatric illness for eight to 10 years. We're not talking here about an 18-year-old woman who suddenly got depressed and is having suicidal thoughts and is looking for MAID. That kind of patient is not what we're talking about. We're talking about people who have suffered interminably over a number of years.

[*Translation*]

Mr. René Arseneault: Thank you, Dr. Smith.

I will be quick since I do not have much time left.

What do you say to those who disagree with you? Dr. Mishra told us for instance that there is no proof that psychiatric conditions are irreversible.

[*English*]

Dr. Derryck Smith: Again, at the risk of being repetitive, I want to go back to the court decisions. The court decisions are where facts are established and rulings are made. The honourable gentleman's opinions were tested in court and found not to hold any water, so the court clearly found, when they heard all the evidence from a whole bunch of experts, including psychiatrists, people for and against, that psychiatrists are clearly able to distinguish between people who are suicidal and people who are seeking MAID. I rely on court decisions because the facts or the crucible of the truth come out of the cross-examination.

[*Translation*]

Mr. René Arseneault: Thank you very much.

Mr. Roberge, you represent 36,000 members of the Canadian Bar Association, or CBA. I read your report summary.

You made recommendations regarding the safeguards to be incorporated into the current Criminal Code provisions for persons suffering exclusively from mental illnesses who will seek MAID once it is allowed in 2023. How would you compare them to those you would propose?

● (1505)

Mr. David E. Roberge: At this point, actually...

[*English*]

The Joint Chair (Hon. Yonah Martin): You have less than a minute, Mr. Roberge.

[*Translation*]

Mr. David E. Roberge: Thank you, Madam Chair.

At this point, the CBA has not made any specific recommendations for safeguards. It has instead stated legal parameters that the government should consider to ensure that the measures adopted align with the criteria in the Carter decision, the Constitution, and the rule of law.

Mr. René Arseneault: Excuse me for interrupting.

I think you are referring to seeing whether expertise in this area could help us adopt safeguards.

Is that up to the CBA or criminal law specialists?

Mr. David E. Roberge: Actually, what I could...

[*English*]

The Joint Chair (Hon. Yonah Martin): Your time is up, so I will have to move on. Thank you.

Monsieur Thériault, you have five minutes.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Thank you, Madam Chair.

I would like to take the opportunity to ask a legal specialist who is here today something that I was asked in the past 24 hours and that I could not answer on the spot.

Mr. Roberge, in its report, Quebec and its special commission on the evolution of the end-of-life care act chose not to proceed and not recommend that the bill tabled this morning open the door to mental illness as the sole medical issue.

If we were to follow this recommendation and bill C-7 and its sunset clause were indeed adopted, what effect would that have on coordination or consistency?

Do you think Quebec would then have to abide by that decision? Would it have some autonomy, leeway? We are well aware that the regulatory frameworks are not necessarily in the Criminal Code.

In your opinion, what would happen from a legal point of view?

Mr. David E. Roberge: You know that I am here representing the CBA working group and that we have not specifically addressed the matter you are raising. That being the case, I cannot respond in detail to a hypothetical situation about which we do not have any concrete information.

What I can say, on behalf of the CBA, is that we have already stressed several times the importance of adopting a pan-Canadian approach that will allow for legal harmonization. Moreover, in Truchon and Gladu v. Attorney General of Canada, Justice Beaudoin, who was then with the Superior Court of Quebec, highlighted the issues relating to conflicting laws. Particular attention will of course have to be paid to aligning the laws between the two levels of government.

Mr. Luc Thériault: In terms of the practice on the ground, I have heard before, with regard to other aspects of MAID, that the most restrictive act was often the rule applied in practice.

Do you think that would be the case with this matter?

Mr. David E. Roberge: Once again—

Mr. Luc Thériault: No, okay.

Mr. David E. Roberge: —it is not the working group's mandate to issue that kind of opinion.

What I can say is that it is always difficult to compare regimes because some provisions are more restrictive while others are more lax. It would be difficult for me to comment on this in the abstract.

Mr. Luc Thériault: Okay. Thank you.

Dr. Smith, what I understood from the expert report provided is that the patients likely to request MAID are those who would not have access. In other words, persons with personality disorders that might involve suicidal tendencies are not necessarily those who would have access and meet the criteria initially.

Is that correct?

● (1510)

[*English*]

Dr. Derryck Smith: Thank you for that question.

It comes back to the point I made, which has come up repeatedly in the court decisions, that it's the whole person you look at, not the diagnosis. When I first saw cases in the Benelux countries with personality disorder, I thought that this was terrible and that there must have been a mistake.

I went to Belgium and I sat down with my colleagues there, and we went over the cases in great detail. The devil is in the details with this. You're looking at the whole person, not a diagnosis. The people who have had personality disorders and received MAID have been suffering for years and years with an intractable illness that is typically resistant to medication and frequently resistant to psychotherapy, and it is causing them enormous distress. You have to let go of the notion of what the diagnosis is and focus on what the suffering of the person is.

This is why the courts have been so effective, because they have only one or two people in front of them at one time. They can look very carefully at it.

[*Translation*]

Mr. Luc Thériault: Among the recommendations, however, a certain number of safeguards emerge and are highlighted.

The second recommendation refers to incurability. It says that “the incurability of a mental disorder cannot be established in the absence of multiple attempts at interventions with therapeutic aims”. So that means that incurability does not refer to a state of crisis, but rather to a mental disorder being diagnosed as chronic. In that case, the person could be eligible for MAID at a given point.

Is that correct?

[*English*]

The Joint Chair (Hon. Yonah Martin): Actually time is up. Could we have a very quick response, Dr. Smith?

Dr. Derryck Smith: These are people with chronic illnesses who have been suffering for many years, and incidentally I agree entirely with all the recommendations in the final report of the expert panel. I had nothing to do with this expert panel. I came at it as an interested party and I read it. I have no problems with any of those recommendations.

The Joint Chair (Hon. Yonah Martin): Thank you very much.

Now we'll have Mr. MacGregor for five minutes.

Mr. Alistair MacGregor (Cowichan—Malahat—Langford, NDP): Thank you very much, Madam Joint Chair.

I too, following other committee members, would like to thank our witnesses for helping guide the committee through this very important study.

Professor Smith, maybe I'll start with you. The report we have been discussing has noted that the presence of many of the mental disorders has been strongly correlated with certain social, economic and environmental inequalities, such as poverty, unemployment and homelessness. In my own riding of Cowichan—Malahat—Langford, we are going through some really bad effects of the opioid crisis. A lot of people are suffering through a lot of trauma.

In your opening statement you did state that with respect to vulnerable people, but I'd still like you to expand a little bit, because I do see on the streets of my riding in my home communities a lot of people who are obviously suffering from mental disorders and a lot of internal anguish. As a committee, we just want to know whether those inequalities that we see might ever influence a person with a mental illness to make a request for medical assistance in dying. I'm just worried that there is such an inequitable access to proper services for so many people out there.

Dr. Derryck Smith: There's no doubt a great inequality in access to services for many people with psychiatric illness. They are disadvantaged with respect to getting the kinds of treatment they need, but that is becoming true in all other parts of medicine as well. In my province, almost one million people don't have a family doctor, so we're facing a crisis in terms of access to health care.

That's why I think you have to look at the individual case, not at groups of people who may be disadvantaged but at the individual patient who is sitting down in front of you having a discussion about whether or not MAID is an option for them. They probably will have accessed many services by that point. If they've accessed no services, then, of course, as a doctor, as a psychiatrist, I'm going to recommend that they have treatment.

The people who are doing assessments are not blind to the treatment thing, and if there's an obvious treatment that could be offered to the person to relieve their suffering, then by all means we would try not only to recommend it but to arrange it. We're not talking about people who have never been treated or who can't access services. We're talking about people who have been in treatment for years and years and are not improving and are still suffering interminably.

We should all work to get rid of inequalities in the health care system, particularly for disadvantaged communities, but I don't think that necessarily has much to do with a psychiatric illness and MAID.

● (1515)

Mr. Alistair MacGregor: I have a follow-up question. The requirement in the Criminal Code is that a person who is seeking MAID is capable of making decisions with respect to their health. Is there anything that you would like our committee to take note of if there are any issues when you're assessing the capacity of a person with a mental illness to make a request for MAID? Is there anything that we need to really take note of? Does the Criminal Code need some finessing in that respect?

Dr. Derryck Smith: There's no doubt that a competency assessment is part and parcel of every MAID assessment. Doctors do this all the time because we can't do a single service with a patient—we can't do surgery or do psychotherapy or give medications—without permission, and the person must be competent. Doctors do this routinely.

In the case of MAID, however, you may need to up the ante a little bit and ensure that there are instruments like the MacArthur competency tests or other instruments that can be used. The competency part of the assessment takes a good chunk of time. We want to make sure before recommending someone for MAID that they are truly competent. I think the other thing to keep in mind is that psychiatric patients like everyone else are assumed to be competent until they are proven otherwise. We don't assume that just because you have schizophrenia or depression or a personality disorder you're not competent. You are considered to be competent until we show otherwise.

Mr. Alistair MacGregor: Thank you.

The Joint Chair (Hon. Yonah Martin): There's less than 30 seconds.

Mr. Alistair MacGregor: Maybe I'll leave it there, Madam Chair. Thank you very much.

The Joint Chair (Hon. Yonah Martin): Thank you.

I'll turn this over now to our other joint chair, Monsieur Garneau.

[*Translation*]

The Joint Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)): Thank you very much, Senator Martin.

Let us begin with the senators' round of questions.

Since Senator Dalphond is away today, I will give each of the first three senators four minutes of speaking time. We will begin with Senator Mégie.

Senator Mégie, you have the floor for four minutes.

Hon. Marie-Françoise Mégie (Senator, Quebec (Rougemont), ISG): Thank you, Mr. Chair.

I would like to thank the witnesses for helping us towards a decision.

My question is for Dr. Smith.

Is there a specific diagnosis of mental illness that is stronger, indicating that it is an incurable illness?

Of course all the usual investigations would have to be done, bearing in mind all the relevant considerations.

Are some mental illnesses diagnosed as incurable?

[*English*]

Dr. Derryck Smith: Thank you for that question.

There are certainly forms of mental illness that are incurable and terminal, and I'm referring here to the dementias. Alzheimer's and Lewy body dementia are all going to kill people eventually, so that's certainly one category of psychiatric illness for which there is no debate about that.

But it's not about whether the illness is incurable. Some people would have us believe that we should hold on for years and years waiting for some new treatment to come down the line. What that's doing is prolonging the suffering of a person who is actively seeking their death to relieve intolerable suffering.

I don't think “incurable” is necessarily what we want to look at. We want to look at whether there are treatments available that are acceptable to the person who has been through 10 years of treatment, that are going to improve their functioning. If the answer to that is no—in other words, there are no treatments or there may be some treatments but they're not acceptable to the patient—then my understanding of the law is that they are eligible for consideration for MAID.

● (1520)

[*Translation*]

Hon. Marie-Françoise Mégie: Thank you.

My next question is also for you.

In our society, mental illness is highly stigmatized. To what extent might that influence a clinician's decision when evaluating a person who has requested MAID?

[*English*]

Dr. Derryck Smith: That's a very interesting question as well. I have to tell you that, when people ask me what I do for a living, I tell them I'm a medical doctor first and a psychiatrist second. The seat of all psychiatric illness is the human brain, which the last time I looked was part of the body and part of the human experience. Our personality, as we describe it, lies in the frontal lobes of our brain, so I'm very much opposed to this dichotomy between physical illness and mental illness. These are all disorders of the human body—and, in this case, mostly the human brain.

I don't have a problem sorting out whether people should or shouldn't. We have pretty clear criteria that are put down in the legislation. We have new criteria in Bill C-7. Assessment could involve a skilled clinician who knows what they're up to in psychiatry and a second assessor, and maybe even talking to the family doctor and to the patient's family. These assessments take literally hours and involve a wide variety of people—the patient, the doctor, a couple of assessors and the patient's family.

I can remember one assessment I did, in which I spent three hours talking to each of the children of a man who was seeking MAID. I want to make sure of what everybody's opinion is. In the end it's up to the individual person, but we want to listen to what other people have to say when approaching that decision.

[*Translation*]

The Joint Chair (Hon. Marc Garneau): Thank you very much, Senator Mégie.

I will now give the floor to Senator Kutcher.

[*English*]

Senator Kutcher, you have four minutes.

Hon. Stan Kutcher (Senator, Nova Scotia, ISG): Thank you very much, Mr. Chair.

Please give a very short answer to my first question, Dr. Mishara.

In your testimony you talked about MAID assessments. Have you ever conducted a MAID assessment?

Prof. Brian Mishara: I have not conducted a MAID assessment, but I've certainly assessed large numbers of people who wanted to have their lives ended.

Hon. Stan Kutcher: Thank you very much. That's fine, Dr. Mishara. We're talking about MAID, sir.

Mr. Chair, could you ask Dr. Mishara to provide to this committee in writing, in a timely manner, the evidence for a couple of the assertions he made? He was talking about conducting MAID assessments, and he said that large numbers of mistakes are made in the MAID assessment. Could he give us the evidence for that?

The other thing he said is that “every single person who calls a crisis line meets the MAID criteria.” Could he provide us with the evidence for that as well?

Thank you.

The Joint Chair (Hon. Marc Garneau): Okay. Senator, I will follow up with the clerk and with Mr. Mishara after this meeting.

Hon. Stan Kutcher: Thank you so much.

For Dr. Smith, the Royal College of Physicians and Surgeons of Canada has standards for psychiatric competencies, and in those competencies they expect a psychiatrist to be able to conduct capacity assessments, competency assessments and cognitive performance assessments, and to assess and manage suicidal behaviour.

Do you, as a MAID assessor and a psychiatrist, have the capacity and competencies to conduct these assessment properly and thoroughly?

Dr. Derryck Smith: Yes. I don't want to be overly enthused or state things that are not true for me, but I think all psychiatrists in Canada have a vigorous training and licensing system. I think any psychiatrist who wants to is competent to do all of those things. We have to assess competency on a case-by-case basis on a regular basis. We have to look at capacity. We have to take into account the views of the family of the patient and the family doctor who has referred the patient. These are all things that happen routinely.

When it comes to MAID, you're not looking at a unique set of skills. You're looking at using the same skills psychiatrists have to answer a particular question, and that is, “Does the person who is seeking assistance in dying, who is sitting of front of you, meet the criteria established under law?” That's the basis of a MAID assessment. It may take three hours to do that, but that is really what we're up to. We're doing a clinical assessment and interpreting the clinical findings against the requirements in the law for assisted dying.

• (1525)

Hon. Stan Kutcher: If you, as an assessor, are not certain about whether the person is suicidal or if you're not certain about whether the person has the capacity to provide free and informed consent, what's your standard procedure? How do you go ahead?

Dr. Derryck Smith: As with all patients about whom I'm not certain, I'd get a second opinion. There's nothing that says you have to have only two assessors. I don't do a lot of assessments. The assessments I get involved with involve cases in which there are two assessors and they can't decide on an issue when it involves a psychiatric illness. We're at liberty to call up our colleagues and bring in other assessors. We want to make sure we get this right.

This is an irrevocable decision. This is not a decision that anyone—the people who assess, the patient, their family or the providers—takes lightly. We must make sure we get it right. I think using the skills of the psychiatrist and the backup of our colleagues in the community, we have ample resources to get this right in assessing an individual patient.

The Joint Chair (Hon. Marc Garneau): Thank you very much, Senator Kutcher.

We'll now go to Senator Wallin.

Senator Wallin, you have four minutes.

Hon. Pamela Wallin (Senator, Saskatchewan, CSG): Thank you very much.

I'm sorry, but we're having problems with the video here. Can you hear me?

The Joint Chair (Hon. Marc Garneau): Yes, we can hear you well.

Hon. Pamela Wallin: Thank you.

I'd like to go back to Dr. Smith as well, and just follow up on something that Dr. Kutcher raised.

When it's stated that everyone who calls a suicide prevention hotline is eligible for MAID, I would gather you don't agree with that.

Dr. Derryck Smith: Thank you for that question.

Not only do I disagree with it, I think it's preposterous. People who call suicide hotlines may be in a situational adjustment—they've broken up with a loved one in their family or they've been fired from their job. These are not the kinds of patients who we're thinking about at all for MAID.

We're talking about patients who have been suffering from mental illness, psychiatric illness, diagnosable illness, who have been treated for multiple years by multiple treatments and have seen many psychiatrists and therapists. Those are the sorts of people likely to be eligible for MAID.

The vast majority of people who call suicide hotlines are nowhere close to being considered for MAID. That's really a red herring.

Hon. Pamela Wallin: Okay. I would also like to follow up with you on your comments about Alzheimer's and dementia, which are an extreme form of mental illness. Again, it comes back to the issue here, which is, if that is the case and if mental illness can in fact be the sole reason to access MAID, we come back to the issue of advance requests here, because how else could that happen for somebody who was going down that particular road? How do you look at that dilemma?

Dr. Derryck Smith: Thank you.

This is one of my passions in life. I think we're all facing, unfortunately, a wave of dementia that's going to affect most of the people in this room and on this conference call.

With respect to the other issue, competent minors and psychiatric patients, there are small numbers of patients. The tsunami is dementia. The problem currently is that if you wait too long to apply for MAID, you're going to become incompetent. If you become incompetent, then you are sentenced to five years of sitting around in a home in adult diapers, not knowing who you are, not knowing who your family is, not enjoying life in the least bit, for five or six years. The risk of waiting too long is to have to live through dementia. I've seen it. It's not pretty.

The other risk is that you could make the decision too early. I had a friend, the wife of a physician, who had MAID a year and a half ago. She did not want to go down the road to dementia. She had MAID, in my view, much too early even though she qualified. She missed seeing two of her grandchildren because she did not want to take the risk of dementia.

Yes, I'm all in favour of advance requests for people with dementia.

• (1530)

Hon. Pamela Wallin: However, do you see these as part of the mental illness category in a sense?

Dr. Derryck Smith: Yes, they're part of the functioning of the brain. This is why I think, again, we have this dichotomy between dementia and, say, depression. We understand exactly what dementia is about. We're not quite sure what depression is, but we do know they're both disorders of the brain.

I would much prefer that we were discussing brain disorders and not psychiatric illness or mental illness.

Hon. Pamela Wallin: Dr. Smith, thank you very much. I appreciate that.

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Wallin.

We'll now go to Senator Martin for three minutes.

The Joint Chair (Hon. Yonah Martin): Thank you.

Thank you to all the witnesses who are bringing their expertise to the table.

Dr. Mishara, I note that you have worked as a clinician in suicide prevention and end-of-life care for 50 years. In your opinion does MAID for mental illness blur the line between suicide prevention and suicide assistance? Is it possible to establish this line under a MAID regime?

Prof. Brian Mishara: If it were possible to establish that, those very few rare cases in which a person is doomed to suffer interminably, there would be no debate. If you look at the expert panel report carefully and you try to find some indication of how you differentiate between someone who is suicidal and someone who is requesting MAID, all they say repeatedly is that it is not possible to provide fixed rules. They do not cite a single research study that shows that any human being is capable of differentiating between those two groups.

When Dr. Smith was asked how to determine whether someone is suicidal or they're requesting MAID, he did not give any diagnostic criteria that one could apply, but he said he is capable of doing this. The research is very clear. There is no evidence that you can predict the course of a mental illness, either treated or untreated, using any reliable criteria. The research that has different psychiatrists predicting shows that they don't usually agree. This worries me, because all of the seriously suicidal....

I'll repeat this. I'd love to provide the evidence that Senator Kutcher requested. When someone is seriously suicidal, they feel there is no hope. We are allowed to, against their will, send an ambulance to save someone's life who is in the process or on the verge of killing themselves. Most of them—the vast majority—are very thankful that we did that at that time. They do meet the criteria in the sense that they usually had a long history of mental illness, they had lots of treatments and they were feeling totally hopeless at that moment, but they made a mistake.

How many people were so grateful to be alive when against their will they were saved? I am just so worried that people will needlessly die because we do not have any criteria. Even though people believe they can make that decision, the scientific evidence isn't there, and I challenge you to just look at the expert panel report and try to find what the criteria would be, how someone talking to someone will make that determination.

The Joint Chair (Hon. Marc Garneau): Thank you very much, Senator Martin.

That brings us to the end of our panel, but I want to thank our three witnesses today, Mr. Mishara, Dr. Derryck Smith and Monsieur David Roberge.

[*Translation*]

Thank you very much for your testimony.

● (1535)

[*English*]

Thank you for answering our questions on this very difficult but very important topic. We very much appreciate it.

With that, we will conclude panel number one. We'll suspend momentarily in preparation for the next panel.

Thank you.

● (1530)

_____________________(Pause)_____________________

● (1535)

The Joint Chair (Hon. Marc Garneau): I am going to call us to order and, hopefully, Dr. McKenzie will join us before we get to him.

I want to welcome the two witnesses who are with us at the moment.

From the Canadian Association for Suicide Prevention, we have Sean Krausert. We also have, as an individual, Dr. Valorie Masuda, and very shortly we hope to have Dr. Kwame McKenzie, also as an individual.

Thank you for joining us today. The way we run these things is that you will each have a chance to make a five-minute opening statement. We ask you to respect that five minutes. Please, during the actual panel, put yourself on mute when you're not speaking. If you want to draw our attention to something during the testimony, you can use the "raise hand" feature. Please address your comments through the joint chairs. I am accompanied today by Senator Yonah Martin, who will co-preside over some of this session.

Without further ado, we will start.

Mr. Krausert, if you are ready, please go ahead. You have five minutes.

Mr. Sean Krausert (Executive Director, Canadian Association for Suicide Prevention): Thank you.

Good afternoon, honourable members of this special joint committee. I am Sean Krausert, the executive director of the Canadian Association for Suicide Prevention. Thank you for the opportunity to provide comments as you undertake this statutory review of provisions of the Criminal Code relating to medical assistance in dying and their application.

My organization acknowledges that Canadians who are deemed capable of making such decisions ought to be able to access MAID to exert control over a death process that is already happening. At the same time, efforts to prevent suicide, including healthy messaging across society, mean that we must work towards a future in which no Canadian uses death as a remedy for a difficult and painful life, especially when the challenges being faced by the individual are remediable.

I have several concerns with respect to MAID for those who are not at the end of life and who are suffering solely from a mental disorder. Three of them are policy considerations, and one is very personal.

First is a life worth living. It is imperative that, as a society, we invest in finding ways to alleviate suffering and support people in connecting to a life worth living. Expansion of MAID to include those not at the end of life carries the inherent assumption that some lives are not worth living and cannot be made so.

Second is mental health care. Finding hope and reasons to live are quintessential aspects of clinical care in mental disorders. Having MAID as a treatment option is in fundamental conflict with this approach and is likely to have a negative impact on the effectiveness of some therapeutic interventions, which may lead both patient and provider to prematurely abandon care.

Third is psychiatric policy. Ending the life of someone with complex mental health problems is simpler and likely much less expensive than offering outstanding ongoing care. This creates a perverse incentive for the health system to encourage the use of MAID at the expense of providing adequate resources to patients, and that outcome is unacceptable.

Fourth is my personal story. I likely wouldn't be here today had the option of MAID been available to me in my darkest days. I experienced multiple deep depressions and extreme anxiety through my twenties and thirties. During my worst depression in my late thirties, the pain was unbearable. While I experienced suicidal ideation, I later realized that I actually didn't want to die but rather to end the pain. That ambivalence is common with those considering killing themselves.

While I once saw myself as a burden to my family, I now see that I am a benefit—and not only to them but to my community. I am now relatively depression- and anxiety-free thanks to medication and therapy that finally worked, as well as to finding out that I had severe sleep apnea that had been undiagnosed for decades. Now I have a rich life. I was recently elected as the mayor of my town, and my first grandchild will be born in a few weeks. To think that if, in my darkest and most painful time, I had been given the option of MAID, I might have given up on a future that was better than I could have asked for or even imagined.

CASP believes that we need to consider the broader context of suicide prevention and life promotion for all Canadians.

To this end, we recommend, first, that MAID should not be provided to patients suffering from a condition that does not have reasonable foreseeability of death, unless there is clear scientific evidence that the condition is irremediable. Irremediability must always be objective and never subjective. There is no evidence that concludes that mental illness falls into this category.

Second, increased funding should be available for health care to ensure that treatments are available to patients so that lack of access to treatment does not cause the condition to be deemed irremediable. A patient's refusal to receive treatment should also not equate to irremediability.

Third, extreme caution needs to be taken with MAID and a thought-out, fail-proof, measured system of safeguards needs to be in place so that those most vulnerable will be protected so that MAID does not become doctor-assisted suicide.

Fourth, tools should be made available to health care providers—especially MAID decision-makers—on how to move forward with providing support to the patient in order to avoid premature death.

● (1540)

In short, CASP strongly encourages removal of mental disorder as a condition eligible for medical assistance in dying. To do so will safeguard against the premature death of persons who are suffering from mental illness alone and thereby avoid inadvertently legitimizing suicide as an acceptable option for ending a difficult and painful life.

Thank you for your time.

● (1545)

The Joint Chair (Hon. Marc Garneau): Thank you, Mr. Krausert.

We'll now go to Dr. Valorie Masuda.

Dr. Masuda, you have five minutes.

Dr. Valorie Masuda (Doctor, As an Individual): Thank you, honourable members, for allowing me to present my views to the special joint committee on physician-assisted dying, considering access to MAID for chronic mental illness.

My name is Valorie Masuda. I've been in medical practice for over 30 years, specializing in emergency medicine for 20 years and in palliative care for over 10 years.

I am a MAID assessor and I've been supporting patients with their applications for MAID since May 2016. I work on Vancouver Island, which has the highest rates of MAID deaths in Canada. I'm also a physician certified in the provision of psychedelic-assisted therapy for terminally ill patients suffering from irremediable demoralization, depression and anxiety.

My work in MAID has shown me the scope of reasons why patients wish to end their lives prematurely. Some patients consider dying from increasing debility and dependency and decreasing cognition an option intolerable to them. Some avail themselves of MAID if they anticipate severe symptoms at end of life. Some patients with end-stage chronic disease may experience very extended periods of debility and suffering, and although their prognosis is unpredictable, they are still on a dying trajectory.

I am a palliative physician, and therefore my duty is to ensure that I provide the patient with every available method to alleviate their suffering, even as I may support their application for MAID. The most difficult symptom to treat is demoralization or the terror that patients experience related to their diagnosis. In the past we had no treatment other than to sedate these people to alleviate this deep, deep suffering, but more recently, some have been choosing MAID to have this state, which is intolerable to them, relieved.

Over the past three years I have legally and successfully treated 20 patients suffering from irremediable demoralization, fear and depression under a section 56 exemption or the special access program. I treat these patients with psilocybin, which is a psychedelic medicine that is highly efficacious and safe. With one treatment I have witnessed a total alleviation of demoralization and fear. It is a treatment that I now offer to patients I see suffering from this kind of distress who may have otherwise accessed MAID.

I understand that some patients with chronic mental illness believe their suffering is intractable and that they should be able to terminate their suffering with medical assistance, but I do not support this. First of all, medical assistance in dying is a program designed to support dying people. Second, our Hippocratic oath is to cause no harm. Delivering a lethal injection to a patient who is not on a dying trajectory is causing harm.

Third, chronic mental illness is an extremely complex and multifactorial condition. It's often caused by early childhood trauma and abuse. It's compounded by unemployment, poverty, isolation and homelessness, and the demoralization and hopelessness are self-treated with substances. The lack of resources for these people perpetuates and compounds the suffering. The promise of pharmaceutical companies to cure depression and anxiety was a lie. Nine per cent of Canadians take antidepressants, and chronic antidepressant use has increased. A quarter of Canadians suffer from depression, and as a result we are seeing a crisis in substance use and an epidemic of drug-related deaths.

For some patients, despite pharmaceuticals, hospitalizations and dramatic interventions such as ECT, the demoralization, hopelessness and depression remain. Their mental suffering appears to be permanently imprinted in their brain, and in many cases substance use becomes a deeply established behaviour response. These patients are considered treatment-resistant because they have not responded to conventional therapy. I have had the opportunity to study the effects of psychedelic therapy in my palliative patients. With the proper supports and treatment context, the medicines reset the brain and give an enormous opportunity to change thoughts and behaviour patterns, but unfortunately they're restricted drugs and unavailable to patients outside of clinical trials.

In summary, Canadians suffering from depression have a constitutional right to have their suffering alleviated, but I do not believe that should be achieved through MAID. Canadians should not have medically assisted suicide because they lack access to basic mental health resources and basic living needs. Pharmaceuticals are not the answer to treating mental illness. Canadians need access to effective and publicly funded treatment programs using publicly funded therapists as well as access to psychedelic treatment.

● (1550)

Effectively treating mental illness gets people back to work, reduces poverty and homelessness, decreases hospital utilization, decreases crime and stimulates the economy. This is where I believe the answer to our mental health crisis lies.

If this special joint committee on MAID recommends proceeding with allowing access to MAID for chronic mental conditions, I would recommend that there be a robust, multidisciplinary review process involving physicians, psychiatrists, social workers and ethicists involved in a patient's MAID application, and that there be a transparent review of MAID cases shared between health authorities and provincial and federal oversight so that we ensure we are not treating social problems with euthanasia.

Thank you very much.

The Joint Chair (Hon. Marc Garneau): Thank you, Dr. Masuda.

Mr. Clerk, was Dr. McKenzie able to join us?

The Joint Clerk of the Committee (Mr. Leif-Erik Aune): Dr. McKenzie is still attempting to join. We have asked him for a contact phone number so we can call him to assist him. We're just waiting for his reply, but he's attempting to join.

The Joint Chair (Hon. Marc Garneau): Okay. Given that, I'm going to start the question period, because we do need to proceed at this point.

Unfortunately, with regard to Dr. McKenzie, we'll try to fit him in at a future meeting, because we need to start with the question period at this point.

I will now turn it over to my co-chair, Senator Yonah Martin.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Garneau.

We'll begin with five-minute questions from MPs.

We'll start with Mr. Cooper for five minutes.

Mr. Michael Cooper: Thank you, Madam Joint Chair.

Mr. Krausert, you said in your testimony that there's no evidence that mental health falls into the category of irremediability. Could you elaborate on that?

Mr. Sean Krausert: I'm advised by those at CAMH in Toronto that they have no evidence and by other prominent researchers in the area—Dr. Mishara and Dr. Sinyor. There's just no evidence. The studies would have to be done.

Mr. Michael Cooper: Thank you for that.

This is for Dr. Masuda, as a MAID assessor. The expert panel report, in the case of mental illness, acknowledges that it would be "difficult to predict for a given individual" in terms of whether they can get better, but that it would be sufficient to take into account past interventions and treatments and determine irremediability on that basis. Could you comment on that in the case of mental illness?

Dr. Valorie Masuda: I'm not a psychiatrist, but in my emergency department lifetime, I have had a lot of experience in seeing chronic illness come back and forth. Patients get into a point of great darkness, and this is where we see patients who attempt suicide. Often these patients have had many interventions in the past, and we know that some of them do recover. We know that some patients with substance abuse do recover.

When we talk about it being irremediable, how do we predict which patients are going to recover from intervention or not? I think that saying a patient has had three courses of anti-depressants does not give predictability as to whether or not this is recoverable.

With more and more science behind the use of medications that have been restricted and are not accessible by psychiatrists or therapists, we are starting to see that there is a potential for recovery for these patients. When we look at what irremediable means in mental illness, I think it's very difficult to predict and to say that this person has tried a lot of things, but their depression they cannot recover from.

● (1555)

Mr. Michael Cooper: Thank you for that.

Dr. Smith said in his testimony that you have to look at the patient as a whole. He seemed to focus almost singularly upon suffering, but the last time I checked the Criminal Code and looked at the definition of what constitutes an "irremediable" condition, "intolerable" suffering is one of the three criteria, but it is not the only criteria. The upper two are an "incurable illness" and there being an "irreversible" state of decline.

As I understand what you're saying, it's not possible to determine if there is an incurable illness and that the patient is in an irreversible state of decline, because there's always the possibility to get better. Therefore, it's not possible to establish irremediability. Am I correct?

Dr. Valorie Masuda: I would say that is correct. The inevitable decline is also a question for people with mental illness, because what we're saying is that they have this mental illness and we expect that they will never get better and that they'll continue to get worse. I'm not sure that's been established either.

Mr. Michael Cooper: Thank you.

Mr. Krausert, as someone who had suffered from mental illness and did get better and has gone on to live a very successful, or seemingly successful, and happy life, can you speak from your personal experience and your work with those who are suffering from mental illness and who are contemplating suicide about the impact that opening the parameters of MAID can have, more broadly, on the culture of suicide prevention in Canada?

Mr. Sean Krausert: It opens the door. Just to be clear, I'm talking about conditions that do not involve a reasonable foreseeability of death.

In the previous session, Dr. Smith spent a lot of time talking about dementia, and I don't understand why we would be going through this mental disorder route. When there's a reasonable foreseeability of death such as there is with dementia, you would go through that route.

I actually don't believe dementia would be excluded if we took out mental disorder.

From personal experience, though, I can say that the darkness that Dr. Masuda talked about is overwhelming. It's painful. It's isolating. It lies to you. It is not the state of mind in which somebody should be making a decision to get married or buy a house or do things in life, let alone end life.

The Joint Chair (Hon. Yonah Martin): Thank you.

Thank you, Mr. Cooper.

Next is Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): I really want to ask a couple of questions to Dr. Masuda.

Dr. Masuda, are you a psychiatrist?

Dr. Valorie Masuda: I am not. I'm a palliative care physician.

Hon. Hedy Fry: You really have no basis for discussing whether psychiatric disease is irremediable, non-irremediable, curable, not curable, etc., or whether a diagnosis can be made on any of those things. We heard from a psychiatrist in the last panel who told us that it is indeed possible to do those things.

Have you used psilocybin on all your patients who request MAID?

Dr. Valorie Masuda: No, I have not, because really what I am looking for—

Hon. Hedy Fry: I have only five minutes, so could you just give me yes-or-no answers, please?

Dr. Valorie Masuda: Okay. I have not on all patients, no.

Hon. Hedy Fry: Psilocybin is just a drug that is under that sort of use right now, but there are no conclusions. There have been no clinical studies about psilocybin, really. However, you're suggesting that it's a cure-all.

Dr. Valorie Masuda: There are studies using psilocybin in the treatment of—

Hon. Hedy Fry: Is it a cure-all? Do you think it's a cure-all for any irremediable problem for people who are not in imminent danger of death?

Dr. Valorie Masuda: I do not think it is a cure-all by any means, but it has—

Hon. Hedy Fry: Thanks very much, Dr. Masuda.

I'd like to go to Mr. Krausert.

Mr. Krausert, I am so glad to see that you are with us today and that you did not succumb to your bouts of depression and suicidal ideation.

You have talked a little bit about the fact that you've been helped. Obviously, this is good. All of us believe it's good. Do you believe, as Dr. Smith said earlier on, that the courts, through very long cross-examination, have actually decided in certain cases, Truchon being one, that trained psychiatrists have the ability to distinguish between suicidal ideation, which could be temporary, and a mental illness that is irreversible?

I noted that the courts also said that the ability to decide whether something is irremediable or not, or intolerable or not, is something that only a patient can decide, because they know what they're living in, they know what they believe, and they know what their options are. Given good options and all of the informed consent, a patient has the right to decide whether or not they qualify as having irremediable suffering and whether they wish to have the treatment that is being offered to them because, for them, the treatment is not something they want to accept.

Courts have ruled positively on those things. Do you agree with those things?

● (1600)

Mr. Sean Krausert: No, I don't. My personal experience tells me that you can be in a state of mind and suffering from severe depression that you believe is going to last the rest of your life. If somebody were to ask me if I was ever going to get better, I would have said definitively that I will not get better and that it has gone on too long.

Hon. Hedy Fry: Thank you, Mr. Krausert, but you are the person living in your own body and, as we heard from Dr. Smith, the whole human being must be looked at here: that whole person with the brain that is now being afflicted by some sort of different way of looking at the world or by mental illness. This is part of the overall human being that we're talking about, and the courts have ruled that this is very different.

You have learned a particular lesson from your own experience that is not necessarily for every human being who is suffering from a mental illness and from a chronic illness for which they decide they do not want any more treatment, which is different from suicidal ideation, by the way.

Do you really believe that this should be done, as MAID is suggesting, on a case-by-case basis, dealing with physicians who have that ability to understand competency, to understand the difference between suicide and and irremediable and intolerable suffering, and who can therefore make those decisions to assist a patient who has all the informed consent available in terms of all their options?

Do you agree that this is an individual thing and that we can't use your experience to define what another human being's experience would be in a given case?

The Joint Chair (Hon. Yonah Martin): Answer very briefly, Mr. Krausert.

Mr. Sean Krausert: The answer is no, because—

Hon. Hedy Fry: Thank you.

Thank you very much, Mr. Krausert. I don't have any time.

Mr. Sean Krausert: Actually—

The Joint Chair (Hon. Yonah Martin): All right. Thank you very much.

Hon. Hedy Fry: Thank you.

The Joint Chair (Hon. Yonah Martin): Next we have Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

My first question is for Mr. Krausert.

I must have read this report ten times or so and I think I will read it again.

You raised a lot of questions that were also on my mind.

Recommendation 8 refers to the consistency, durability and well-considered nature of a MAID request. It says:

> Assessors should ensure that the requester's wish for death is consistent […], unambiguous and rationally considered during a period of stability, not during a period of crisis.

I am glad you are still with us, but from my understanding of the report, even if you had made a request, you would not have been eligible for MAID when you were at your lowest point.

Clarification is provided a bit further on that helped me understand which people were being referred to. One case is mentioned. I will read out an excerpt and you can tell me whether you think this woman should be eligible for MAID:

> 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 hospitalization. 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 (medication and neuromodulatory) treatments and she does not want to try any more. She has no plan to attempt suicide at present.

In your opinion and based on your experience, should this lady have access to MAID following a rigorous evaluation process?

● (1605)

[*English*]

Mr. Sean Krausert: I don't think so.

In the particular case that you gave, the condition has gone on for a long time. It's not unreasonable to think that it's going to last for a long time. Also, to my mind, you said she doesn't want to undergo further treatment. The question really is whether we want to be a party to helping people die prematurely.

I think that, in the absence of absolute evidence, data, that shows objectively that this is never going to be treated so that the suffering can be reduced, we have to say no. I'll tell you, subjectively, that the condition isolates you. The condition lies to you, and it is simply not the truth for so many people. While you might be able to find a case here or there of there being no other way, you're going to find as many cases of people who end their lives prematurely when they could have gotten so much better.

[*Translation*]

Mr. Luc Thériault: Thank you for making the effort to answer my question. It is much appreciated.

[*English*]

The Joint Chair (Hon. Yonah Martin): You have one minute.

[*Translation*]

Mr. Luc Thériault: I am not a psychiatrist, but I think there are moments when treatment, the chronic nature of a mental illness, crosses a line. Essentially, it is as though treating that state, that mental illness, is a form of extended palliative care. The illness is not cured and it is even difficult to control the suffering, the pain. It is in those cases that we see requests for MAID. For people working in palliative care, this seems to be a finding and a request. In my opinion, the answer should be a yes in those cases. So I disagree with you on that.

I do not have a question; I just wanted to make a comment.

[*English*]

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Thériault.

Next we will have Mr. MacGregor for five minutes.

Mr. Alistair MacGregor: Thank you very much, Madam Co-Chair.

I'd like to start my questions with Dr. Masuda.

Thank you so much for joining our committee and helping guide us through this topic. I want to expand on your opening statement in which you were talking about the patients you have helped treat with psilocybin therapy.

For full disclosure to my honourable committee members, I did write a letter of support for that section 56 exemption, because I think new and innovative treatments are necessary.

Dr. Masuda, I know that in a previous exchange with Dr. Fry, she did say that it is not a cure-all. I am just wondering if you could maybe expand a bit on the potential promise that it holds. For instance, are we just on the tip of the iceberg of what this potentially could mean for interventions?

Dr. Valorie Masuda: This is a treatment where, if there's clinical indication, I do offer it—the clinical indication of people who are stuck in a thought process of hopelessness and demoralization, and they are truly stuck.

I had a patient in her early thirties who had extremely complex pain that we could not manage. She had been through a tertiary care unit, she had every conceivable pain option offered to her, and we just could not manage her existential distress. She couldn't communicate. She was a ball of.... She was a mess, weeping.... She couldn't interact with her friends or family. Truly, she was suffering a deep, deep suffering.

She was the second patient in Canada to receive a section 56 exemption. With her, 24 hours later, after administering this one medication, it broke that trap, that place where often you hear psychiatrists and therapists say, “My patient got to a point where I couldn't get past it.” Well, it broke past that, and within 24 hours she had no pain. We were ramping down her pain medication. She was alert and orientated. She could actually talk about death and dying, and she could re-establish the connections between her friends and family.

Since that time, I've had 19 other patients who have had really deep suffering, and we've had no other therapies for this until now. I think this is a breakthrough. I've seen people in a state where they just can't get through, whether they're drinking too much and they can't stop drinking, they cannot interact with their friends and family, or they're stuck in a terror state because they're dying. Within 24 hours, we see a complete change in that.

There are many studies. There are functional MRI studies. We know how these drugs work, but they've been restricted and unavailable to patients.

● (1610)

Mr. Alistair MacGregor: On that, you have experienced the difficulty with applying for a section 56 exemption. There have been a lot of hoops to jump through. In some cases, the wait times have been long and onerous. You have the ability now to speak to a committee that is going to table a report and include recommendations.

From your point of view and from your experiences, what kinds of recommendations would you like to see this committee make with respect to access to psilocybin and further research? Can you elaborate on that point, please?

Dr. Valorie Masuda: Thank you.

The use of psychedelics in the States has now been termed “groundbreaking”. These are groundbreaking interventions.

It's not just about the medicine. It's about giving the medicine in the context of therapy. This is about using psychedelic-trained physicians and therapists. This is groundbreaking. This is a way where, for patients who are stuck in a certain thought pattern and behaviour pattern, we give them a psychedelic and it opens their brain, so that now we can establish new patterns of thought and behaviour. This is a groundbreaking type of intervention, and this is where I think we need to move forward in allowing it for patients with substance use disorders or chronic depression and anxiety.

Where we think there is no treatment, I believe there is a treatment, and we should look at allowing this to be accessible to all Canadians.

Mr. Alistair MacGregor: Quickly, for my final question, in the previous panel, when Dr. Smith was talking about the concept of irremediability, he said that it is a state when no more treatments are available that are acceptable both to the health care provider and to the patient. In your experience, when a patient decides that there are no other options for them that are acceptable, how do you try to move past that when your treatment options might be blocked by the patient's sense?

Dr. Valorie Masuda: It is a very tricky question, because certainly if I have a patient who has cancer, and he or she says that “treatment with chemotherapy doesn't align with my core values”, I have to respect that patient and say, “Even though you're on a dying trajectory, the decision not to use a medical intervention which can prevent dying is actually your right to make.” Mental health is really difficult, because—

The Joint Chair (Hon. Yonah Martin): Thank you. We're over five minutes already, and I wanted to just acknowledge that Dr. Kwame McKenzie has joined us, but his sound hasn't been tested.

Given that it's already almost 4:15, I'm wondering whether we should allow Dr. McKenzie to speak for a few minutes, since he has joined us. I see nodding heads.

Hopefully, Dr. McKenzie, your sound will work for us. You have just a few minutes for your testimony.

Thank you.

Hon. Hedy Fry: Chair, just one thing I wanted to say is that I also signed the letter for psilocybin to be a section 56 exemption. I'm just putting that out.

● (1615)

The Joint Chair (Hon. Yonah Martin): Okay. Thank you.

Dr. McKenzie, go ahead.

If you can condense your remarks, because of time, that would be appreciated. Thank you very much.

Dr. Kwame McKenzie (Professor of Psychiatry, University of Toronto, As an Individual): Thank you very much. I hope you can hear me loud and clear. I apologize. This has been my most embarrassing Zoom call so far this year. I apologize for that, but we've managed to get on.

Thanks very much for allowing me to speak today. I'm honoured to be here.

As you know, I was the chair of the 2018 report by the CCA on MAID and mental disorders as a single underlying medical condition. I was also a member of The Halifax Group, which published a paper on MAID safeguards. Both the CCA report and the Halifax Group report wrestled with the same issues as Health Canada's 2022 expert panel on MAID and mental illness. Those main issues are the ones I've heard you talking about already: eligibility, capacity, suicidality, the intersection between MAID and the social determinants of health or structural vulnerability, and safeguards.

I know you've read the reports, and I'm happy to discuss those, but I thought I would use just a minute or two to draw attention to three things: the possible impacts of COVID-19, social determinants of health, and racial inequity on MAID for mental illness.

To explain the assessment of suffering in mental health problems, it is partly a link to the adequacy of treatment. Also, the social impact of the illness, the social exclusion and the feeling that you have a difficult future ahead of you increase the perception of suffering.

The suffering of people with mental health problems is likely to increase because of COVID-19. We had a crisis of increased rates of illness, increased rates of mental health problems and inadequate access to care and supports before COVID, and things have gotten worse because of COVID itself. That's because of the increased need for services, but also because of staff burnout and decreased capacity of services. We have a greater imbalance between service provision and need.

If the number of people who are not able to access appropriate treatment increases, we have increased numbers who are suffering. Therefore, if we have increased numbers of people suffering, we have to consider what that means for MAID and mental illness.

COVID-19 isn't the only stressor. We have the affordability crisis and curbs on government spending that will impact the suffering of people with mental health problems, because they're making unrealistic, comparative appraisals of where they are in their lives compared to others. As the social safety net comes under pressure and affordability becomes more of an issue, perceived suffering may increase.

Then, there's racial inequality. We all know that COVID-19 has hit indigenous, Black, and other racialized groups hard, but these groups were previously underserved by mental health services. Those disparities are likely to increase. They are also less likely to get the social supports they need. Again, we have a differential increase in suffering.

So far, none of the reports I talked about have properly discussed the differential impacts of MAID on different racial groups. I note that the Health Canada report does suggest that there needs to be consultation with indigenous populations in the implementation of the safeguards, but did not recommend that Black and other racialized groups should be specifically also consulted. I think that's an error.

I'm suggesting that we need to be thinking about an increased focus on how to ensure that every person who is considering MAID, where mental disorders are the single underlying medical condition, would have full access to appropriate and effective medical support. At the moment, we say they need to know about it, but the question is, do we ensure that they actually have full access?

Of course, it's clear that we need to build a system that doesn't only offer the medical support, but also makes sure that people with mental health problems are not socially excluded, living in poverty and believing that they have no future. We have to ensure that people accessing MAID have had proper access to social supports.

● (1620)

Last, we need to ensure that this group, our expert panels, and other groups that are thinking about MAID law have full and considered engagement with Black and other racialized groups so their needs are properly reflected in the transformational laws we're talking about.

All in all, my concern is that our safeguards should focus on ensuring that people have had proper equitable access to all of the treatments and social supports they need to decrease their suffering. This is to ensure that we're not creating an off-ramp for social suffering through MAID.

Thank you very much.

The Joint Chair (Hon. Yonah Martin): Thank you very much, Dr. McKenzie.

I'll turn this back to MP Garneau.

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Martin.

We'll now go to the senator round of questions. Once again, the first three senators will have four minutes each.

[*Translation*]

We will begin with Senator Mégie.

Hon. Marie-Françoise Mégie: Thank you, Mr. Chair.

My question is for Mr. McKenzie.

In view of all the suffering resulting from COVID-19, suffering that we are familiar with and that you just mentioned, I was wondering whether people who are socioeconomically disadvantaged, such as Indigenous, Black or racialized persons, had submitted MAID requests and whether you had any data on that.

[*English*]

Dr. Kwame McKenzie: I'm a psychiatrist, and obviously MAID will essentially be unavailable to people with mental health problems until 2023, so I haven't been able to observe that myself.

[*Translation*]

Hon. Marie-Françoise Mégie: Okay, thank you.

I have a question for Dr. Mesuda now.

In your opening remarks, you said that MAID is for people who are about to die. You must know however that this condition was overturned by Truchon and Gladu v. Attorney General of Canada. With regard to access to MAID, some experts have argued that excluding persons with mental disorders or mental illnesses is a violation of their fundamental rights.

What are your thoughts on that?

[*English*]

Dr. Valorie Masuda: I suppose we look at patients, or Canadians, and say that you have the right to make decisions about how you live and how you die. I don't have an issue with people accessing medical assistance in dying based on their own personal core values. What I do have an issue with is offering medical assistance in dying for people who are really depressed and stuck and who feel that their case is irremediable because of their social determinants of health.

If you are impoverished or if you are isolated, then you feel that there is no end to your suffering, so we need to ensure that all these people have access to food, housing and any treatments that could change the course of their illness.

[*Translation*]

Hon. Marie-Françoise Mégie: I have just a few seconds left?

The Joint Chair (Hon. Marc Garneau): You have one minute left.

Hon. Marie-Françoise Mégie: Thank you.

My next question is for Mr. Krausert and Dr. Masuda. Please answer briefly.

You said that strong measures are needed and referred to multidisciplinary assessment. That is interesting, but I would like to know if one or two measures have emerged from your considerations and discussions with your peers..

● (1625)

[*English*]

The Joint Chair (Hon. Marc Garneau): Why don't you start, Dr. Masuda?

Dr. Valorie Masuda: I have a number of cases where I feel that either family or even health care providers have been coercing a patient to contemplate MAID for a number of different reasons. This is also where I feel there would have to be safeguards. I've seen patients to whom it has been said, “Hey, I see you're suffering a lot here. Have you considered MAID?” It is not uncommon for a patient to experience a physician or a family member or somebody coming up and offering MAID as a really good solution to their problem.

This is where I think we really need multidisciplinary safeguards.

The Joint Chair (Hon. Marc Garneau): Thank you, Doctor.

Dr. McKenzie, did you want to comment very quickly?

Dr. Kwame McKenzie: Yes. I think the Health Canada recommendation of a multidisciplinary team taking assessments over time and getting collateral information is probably the best we can do with our science at the moment. Taking a considered case-by-case approach to this situation is done in various other parts of the world, and I think that's the best we can do at the moment.

The Joint Chair (Hon. Marc Garneau): Thank you very much.

We'll now go to Senator Kutcher.

Senator Kutcher, you have four minutes.

Hon. Stan Kutcher: Thank you very much, Mr. Chair, and thank you to the witnesses.

My first question is for Mr. Krausert.

You talked about MAID opening the door to suicide and the presence of MAID having the impact of legitimizing suicide. Have the rates of suicide in Canada before MAID changed significantly after MAID was instituted? If this was the case, we would expect to see significant increases in suicide rates. Have there been significant increases in suicide rates in Canada after MAID?

Mr. Sean Krausert: The access to MAID for mental disorder alone has not—

Hon. Stan Kutcher: No, I'm not asking about that. You were not talking about mental disorders. You were talking about suicide in general because of MAID. I'm asking you a question on the rates of suicide.

Mr. Sean Krausert: No, I didn't say that. I said that CASP supports the right of individuals who are capable of making decisions to access MAID when death is foreseeable, and we don't take those into account. I do know that in other jurisdictions where this has been entered in, suicide rates did not drop, which means there were additional deaths because of MAID.

Hon. Stan Kutcher: That's pretty clear. Suicide rates didn't go down, to your knowledge, when MAID was being discussed in the public domain.

My question now is for our other witness. It's on psilocybin. We know that for psilocybin, there's an emerging database for its use in palliative care, and that's good.

What proportion of people seeking MAID for mental illness are currently cured or effectively treated by psilocybin?

Dr. Valorie Masuda: I deal with patients who have significant moral distress related to cancer, so that's palliative.

Hon. Stan Kutcher: That's what I heard you say, but we're talking about MAID here, so I'm asking you this question. I don't want the panel to be misguided. What proportion of people seeking MAID for mental illness are cured or effectively treated by psilocybin?

Dr. Valorie Masuda: I can say that currently we don't have access to psilocybin, so we cannot make any claims until we have good clinical trials.

Hon. Stan Kutcher: But in the United States—

Dr. Valorie Masuda: There is clinical data available in the United States.

Hon. Stan Kutcher: What does it say?

Dr. Valorie Masuda: For people with chronic mental illness, and we're looking at chronic depression and anxiety disorders—

Hon. Stan Kutcher: We're talking about MAID, not just chronic anxiety disorders, because that's not the MAID universe. People who are seeking MAID—

Dr. Valorie Masuda: No, this is for chronic mental illness.

Hon. Stan Kutcher: That's not the universe for MAID. We're talking about MAID, so let's focus on MAID. For the people seeking MAID—that's the question—what is the evidence that psilocybin is effective in treating them?

Dr. Valorie Masuda: Well, we don't know that information because—

● (1630)

Hon. Stan Kutcher: So we don't know.

Dr. Valorie Masuda: —we don't have patients seeking MAID for chronic mental illness yet.

Hon. Stan Kutcher: That's fine, so we don't have that information. What you're talking to us about is very speculative, and you're extrapolating from use in palliative care and demoralization to people whose sole underlying condition is a mental disorder.

Dr. Valorie Masuda: No, because there is clinical evidence in the States that MDMA and psilocybin are effective treatments for chronic mental illness as well.

Hon. Stan Kutcher: No, but this is for people seeking MAID.

Dr. Valorie Masuda: Well, we don't know that because people can't seek MAID for chronic mental illness yet.

Hon. Stan Kutcher: There we go. The fact that we don't have evidence and you're extrapolating from other data is important.

Dr. McKenzie, you make really good points, and obviously the social determinants of health are essential to establish. Do you think people seeking MAID who are in precarious living situations, who are racialized or are minorities—anybody like that—should be offered those interventions as part of the assessment of MAID?

Dr. Kwame McKenzie: Yes. I think we should do as much as we can to try to alleviate people's suffering. I'm probably different from the other panellists because I'm a psychiatrist who has seen a lot of suffering over the last 30 years, and I don't want people to suffer needlessly, so I would balance people's rights to make their own decisions with what can be reasonably offered by the state. I'd like as much offered as possible, but in a democracy, everybody can't have everything. We know that, so I think there's a balance.

I'm always really happy to see people being very positive about possibilities of miracle treatments in psychiatry, but I've been doing this for 30 years and I've seen miracle treatments come and go, and I've still seen a lot of suffering in mental health. I focus on the social determinants of health because some of them can be ameliorated.

Hon. Stan Kutcher: All right. Thank you very much.

The Joint Chair (Hon. Marc Garneau): Thank you, Doctor.

Thank you, Senator.

We'll now go to Senator Wallin.

Hon. Pamela Wallin: Thank you, Chair.

If I could, I have a quick point for Dr. Masuda.

You made the statement—and we've heard this from other witnesses from time to time—that MAID is being offered up as a solution to psychological, psychiatric or social problems, etc. Do you have any evidence or the name of a doctor or a MAID provider who has offered up MAID without process to somebody who is just feeling down or doesn't have a place to live?

I'm sorry, but I can't hear you.

The Joint Chair (Hon. Marc Garneau): Dr. Masuda, we see that you're unmuted, but we can't hear you.

Hon. Pamela Wallin: Okay.

Well, Chair, if I could get you.... Again, this is kind of a recurring theme, but when statements such as that are made, it would be very helpful for the committee here to have actual evidence, because, as I think I have stated before, if people are not going through the correct MAID process, then they have clearly broken the law, so we should be informed about that.

If I could, I would go to Dr. McKenzie. We heard some testimony here—and the statistics show—that those who choose MAID are generally white, wealthy and willing. Is it your position that others, maybe minority groups that are facing severe social issues, aren't being given the opportunity or aren't being presented with this as a possibility or a choice that they might want to make at some point?

Dr. Kwame McKenzie: No, that wouldn't be—

Hon. Pamela Wallin: Okay, thanks. I just wanted to clarify.

Dr. Kwame McKenzie: My position would be that most of the information to date that we have on MAID at the moment is...well, it's obviously historical, but we haven't hit a steady state on the numbers of people who are eventually going to be getting MAID in Canada.

We also have changes in the law coming through, as well as changes in guidelines and safeguards, so we don't know exactly where we're going to end up. My worry is just to make sure that we don't end up in a situation where we haven't done enough and MAID is considered an off-ramp for social suffering. I don't think we're there yet, but I don't want us to get there, so it's about being mindful, rather than saying that there is data at the moment showing that we have high numbers of indigenous or racialized or low-income people who are applying for MAID at the moment.

● (1635)

Hon. Pamela Wallin: No. The statistics in fact say the opposite.

So what kind of a safeguard would you propose, then? Is there something there that you think would prevent that slippery slope?

Dr. Kwame McKenzie: Well, I'm not sure that it's a slippery slope, but I want to make sure that we're mindful when we're thinking about it. Just as we tend to say that we want to make sure everybody has had an opportunity for all of the medical treatment that they require, I was flagging that it would be good to also make sure that people have a proper social assessment and they get access to all of the social supports that are required.

I'm not making any grand statements that I know there are huge differences. I just know that there are huge differences in mental health needs coming through because of what we're going through at the moment, and I wouldn't want us to be blindsided by that, so it really is a consideration, then, and trying to look forward rather than saying that there are issues right now.

Hon. Pamela Wallin: All right. So you're tying that more specifically to the COVID situation.

Dr. Kwame McKenzie: Well, there's the COVID situation, but in places like the U.K. they've had the biggest drop in the standard of living since 1950 because of the economic climate and the possibility of a bigger or wider war. I think it's not just COVID. We have climate change and we have significant economic problems that are headwinds that we seem to have to be thinking about. We know that this will change the rates of suffering and the perception of suffering.

That was really the flag I was trying to raise here rather than anything else. I was trying to be balanced. I think if I'd had a bit more time, I'd probably have come across as a bit more humble in my assessment.

Hon. Pamela Wallin: I think it was just important to clarify. Thank you for that.

[*Translation*]

Mr. René Arseneault: Thank you, Mr. Chair, a point of order.

The Joint Chair (Hon. Marc Garneau): Go ahead, Mr. Arseneault.

Mr. René Arseneault: I did not want to interrupt Senator Wallin, but I think she asked Dr. Masuda an important question, which she was unable to answer.

Will Dr. Masuda agree to answer the Committee through the clerk?

The Joint Chair (Hon. Marc Garneau): That is exactly what I was going to suggest.

Thank you, Mr. Arseneault.

[*English*]

For technical reasons, Dr. Masuda, you were not able to answer the question from Senator Wallin. We would appreciate a written answer to the question she posed to you. Can you give us a thumbs-up that you'll follow through on that? Okay. Thank you very much.

We'll now go to Senator Martin for three minutes.

The Joint Chair (Hon. Yonah Martin): Thank you, Mr. Chair.

Thank you to all of our witnesses.

Mr. Krausert, could you explain what CASP's position is on capacity for MAID for a mental illness or disorder? Could you explain to us what full disclosure for informed consent for MAID for a mental illness would have to look like?

Mr. Sean Krausert: I think capacity has to be assessed by the doctor, obviously taking into account the condition from which the person is suffering. When we're talking about mental disorders, there is some influence on capacity, that being my experience.

As far as full disclosure is concerned, I think we have to disclose that with a particular condition, for example, there's anywhere between a zero and 100% chance of irremediability, because we don't have the data. I don't know how it could be concluded subjectively without the objective data supporting it. That sort of disclosure I think needs to be done. As the report talks about, there has to be some sort of subjective shared understanding on such things between the practitioner and the patient. It's so subjective.

We bend over backwards in our Criminal Code to protect innocence. People have to be proven guilty, even if it means some guilty people get let go. I'm suggesting that safeguards have to be in place to ensure that those who would regret it and all those impacted by it.... Don't forget that there's a ripple effect between friends, co-workers and contacts. For every one of these deaths, we're talking about a major, major impact. It's not a decision just for the person. It's a decision for the community. We have to make sure that we really have those safeguards in place.

● (1640)

The Joint Chair (Hon. Yonah Martin): Thank you very much, and thank you for sharing your personal experience and story. It really gave us a sense of the insights we need to have. I think your voice today was very important.

Thank you, Chair.

The Joint Chair (Hon. Marc Garneau): Thank you, Senator Martin.

Mr. Michael Cooper: I have a point of order, Mr. Chair.

The Joint Chair (Hon. Marc Garneau): Mr. Cooper, go ahead.

Mr. Michael Cooper: Thank you very much, Mr. Chair.

I know that we are scheduled to go in camera to consider two motions, but I would submit that just in the interest of time, so that we wouldn't have to log in again, there would be some merit in not going in camera. Speaking to my specific motion, at least, I think it would be appropriate that the motion be considered out of camera, in public.

It's a motion requesting that this committee dedicate six hours to the study of the effectiveness, compliance and enforceability of existing safeguards under the Bill C-14 and Bill C-7 regimes.

The Joint Chair (Hon. Marc Garneau): Thank you, Mr. Cooper. We previously made the decision that we will go in camera for this discussion and for other business as well.

Mr. Michael Cooper: Mr. Chair, I would just put forward a motion that we consider my motion in public, not in camera.

The Joint Chair (Hon. Marc Garneau): Very good. Let's put that to a vote.

I would like to see a show of hands for committee members who would like to—

Mr. Michael Cooper: Mr. Chair, I request a recorded vote.

The Joint Chair (Hon. Marc Garneau): A recorded vote is fine.

Those who are in favour of supporting the motion from Mr. Cooper, please raise your hand.

Mr. Michael Cooper: I requested a recorded vote, a roll call.

The Joint Chair (Hon. Marc Garneau): Very good.

Mr. Clerk, go ahead and call the names.

The Joint Clerk (Mr. Leif-Erik Aune): Mr. Chair, I should inform you that it is out of order to propose a motion on a point of order.

The Joint Chair (Hon. Marc Garneau): That is a good reminder. Thank you, Mr. Clerk.

I'm afraid your point of order is out of order, Mr. Cooper.

I want to finish off by thanking our witnesses today. We very much appreciate it. On behalf of the committee, we thank you very much, Mr. Sean Krausert, Dr. Masuda and Dr. McKenzie. We're really glad we got you. Even though there were some technical difficulties, we very much appreciate your input into this important work of our committee.

With that, I will suspend. There will be a little time before we are able to come back in camera. All of the members should now go to the new link for the in camera session.

Mr. Clerk, as soon as we have that quorum, we will be in a position to start our third hour.

Thank you.

[*Proceedings continue in camera*]

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