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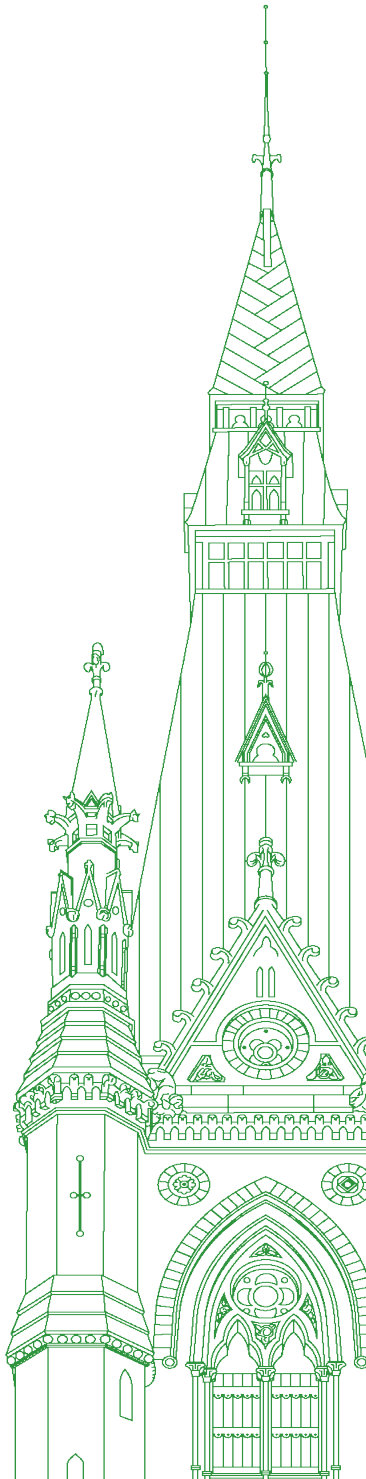

Co-Chairs: Mr. René ArseneaultThe Honourable Yonah Martin

Special Joint Committee on Medical Assistance in Dying

Tuesday, November 21, 2023

● (1835)

[*English*]

The Joint Chair (Hon. Yonah Martin (Senator, British Columbia, C)): Good evening and welcome to this meeting on the Special Joint Committee on Medical Assistance in Dying.

I'd like to begin by welcoming members of the committee and all our witnesses, as well as those watching on the web.

My name is Yonah Martin. I'm the Senate's joint chair of this committee. I'm joined by René Arseneault, the House of Commons joint chair of the committee.

Today we continue our examination of the degree of preparedness attained for a safe and adequate application of medical assistance in dying where mental disorder is the sole underlying medical condition, in accordance with recommendation 13 of the committee's second report.

I want to remind members and witnesses to keep microphones muted unless recognized by one of the joint chairs. As a reminder, all comments should be addressed through the joint chairs. When speaking, please speak slowly and clearly. For those appearing by video conference, interpretation is available. You have the choice, at the bottom of your screen, of floor, English or French.

With that, I wish to welcome our witnesses this evening.

Thank you very much for your presence.

As individuals, we have Jocelyn Downie, professor emeritus at the Health Justice Institute of Dalhousie University's Schulich School of Law, and Trudo Lemmens, professor and Scholl chair in health law and policy at the University of Toronto's faculty of law, by video conference.

From Health Canada's strategic policy branch, we have Jocelyne Voisin, assistant deputy minister, accompanied by two officials with the health care programs and policy directorate: Sharon Harper, director general, and Jacquie Lemaire, senior policy adviser. From the Department of Justice, we have Myriam Wills, counsel, criminal law policy section.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): I didn't want to interrupt you, Madam Chair, but we always have the same problem at the beginning of the meeting. The sound in the room is much too loud for the interpreters.

If I don't want to hurt my eardrums because the sound is too loud in my ear, the sound should be adjusted. Sound checks should be done on site at the start of the meeting, as is done for remote participants.

It bothers me a bit to interrupt you at every meeting, but the situation will remain the same until the end if sound tests are not part of the procedure.

I'm sorry, but that's life.

[*English*]

The Joint Chair (Hon. Yonah Martin): I'm assuming the sound is being adjusted.

[*Translation*]

Mr. Luc Thériault: If you spoke, that would allow us to set the sound volume with the interpreters.

[*English*]

The Joint Chair (Hon. Yonah Martin): All right. I can do the list of witnesses and the order. As I'm speaking, hopefully they're adjusting the sound. Let me just do that.

I'll wait before having our first witness.

I am told the sound is okay now. Very good.

We will begin with opening remarks of five minutes from each of our witnesses: Professor Downie, followed by Professor Lemmens and the federal official, Ms. Voisin.

Professor Downie, the floor is yours for five minutes.

Dr. Jocelyn Downie (Professor Emeritus, Health Justice Institute, Schulich School of Law, Dalhousie University, As an Individual): Good evening. Thank you for the invitation to speak with you.

My name is Jocelyn Downie, and I'm a professor emeritus in the faculties of law and medicine at Dalhousie University. I've been honoured to be made a fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences, and to be named to the Order of Canada for my work on this topic.

I start tonight with the committee mandate “to verify the degree of preparedness attained for a safe and adequate application of MAID” in MD-SUMC situations, with particular reference to standards of practice referred to by the expert panel.

On this metric, preparedness has already been established through your hearings. You know that the model practice standard was published in March 2023, and you have received uncontroverted evidence that the professional regulatory bodies are ready. However, in case you go beyond this mandate and/or adjust the metrics, more needs to be said.

First is the charter. A barrier to access to MAID based on a diagnosis of a mental disorder is a limit on the section 7 and 15 rights of persons with mental disorders. The arguments for this can be found in the testimony of numerous witnesses, briefs and legal decisions. A purported lack of preparedness might be presented as an attempt to justify the limits on the rights under section 1. However, that argument would fail.

The federal government is prepared. It has amended its reporting regulations, created an independent expert panel on MAID and mental illness, created an independent expert task group to draft and model practice standards, funded the independent national accredited curriculum to train MAID assessors and providers, and supported a knowledge exchange workshop that brought together MAID assessors, providers and psychiatrists from every jurisdiction in Canada to prepare together for the implementation of MAID MD-SUMC. Furthermore, the very people tasked with regulating the conduct of MAID assessors and providers have confirmed for you that they are prepared.

Clinical preparedness has been established through the delivery of multiple training sessions across the country, the existence of a community of practice among expert psychiatrists coast to coast, the experience that MAID assessors and providers already have from assessing MAID requests from persons with mental disorders, the experience that psychiatrists already have from acting as consultants for both track one and track two patients, and the development of protocols and policies at the programmatic level.

Any lack of political preparedness is not a justification for limiting charter rights. Any purported lack of clinical preparedness by some psychiatrists is not a justification for limiting charter rights. Not all clinicians in Canada were prepared for MAID when it first came in. Any individual psychiatrist who does not feel prepared is under no obligation to participate in MAID. It is abundantly clear that psychiatrists from across the country—including eminent psychiatrists, eminent experts in psychiatry—are prepared.

Some might say that not all Canadians are prepared. However, not all Canadians were prepared for MAID. Furthermore, no person is ever compelled to get MAID. The protection of charter rights does not and cannot wait for some subset of the public to be prepared. A preparedness claim, therefore, cannot serve to save the limits on charter rights that any further delay would entail.

Now let's turn to the division of powers under sections 91 and 92 of the Constitution Act. The federal Parliament must approach the issue of preparedness with attention to its own jurisdiction. It is abundantly clear that it is prepared. Even if you aren't persuaded that all the provinces and territories are ready—which is counterfactual, given the unequivocal evidence from the provincial-territorial regulatory colleges, as well as information available about MAID programs and PT oversight mechanisms—the division of powers dictates that you not delay further.

Look to history. Consider, for example, the 1969 act that made abortion legal under certain conditions. The act was passed in May 1969. Royal assent was given in June 1969. The abortion provisions came into force in August 1969. Parliament didn't wait for the newly required therapeutic abortion committees to be established in the hospitals across the country. The federal Parliament made the changes it felt were right to protect women's rights, and it left it to the provinces and territories to do what was necessary to implement the changes at their level.

There's also a logical and ethical basis for this view of preparedness. If the federal Parliament were ever to tie the changes to the Criminal Code to provincial and territorial preparedness, it would be allowing the provinces and territories to subvert the federal Parliament's decisions with respect to criminal law. It would also be allowing any laggard provinces and territories to hold hostage those other provinces and territories that got ready. It would allow the protections of the charter rights of people in the provinces and territories that got ready to be blocked by those provinces and territories that chose to not be ready. This is something the federal Parliament should not be a part of.

● (1840)

I leave you with one final thought. The trial decision in Carter was released in 2012. Truchon was decided in 2019. Bill C-7 was passed in 2021. It is now 2023. A further delay would take us to 2025. Justice delayed is justice denied.

Thank you.

● (1845)

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

We will go to Professor Lemmens.

You have the floor for five minutes.

[*Translation*]

Dr. Trudo Lemmens (Professor, Scholl Chair, Health Law and Policy, Faculty of Law, University of Toronto, As an Individual): Good evening, chairs and members of the committee.

[*English*]

Parliament's core obligation is to protect the life and promote the well-being of Canadians. Expanding MAID to include it for reasons of mental illness is an unprecedented threat to that. It appears driven by, one, a flawed claim or perception of constitutional obligation; two, a strong prior commitment to expansive MAID by a core of people with dominant input in the policy process who overwhelmingly emphasize the need for access, not protection; and three, a lack of appreciation of how problems in jurisdictions that allow it will be even more serious here, because of weaker legal standards.

First, there is no constitutional requirement to introduce death to "solve" often severe suffering from mental illness. This is emphasized in a letter to cabinet by 31 Canadian law professors, including constitutional and human rights scholars; in several academic publications, including our forthcoming article; and in committee submissions by law scholars and the vulnerable persons standard.

These also clarify why it is not discriminatory to limit access to MAID. No court—definitely not the Supreme Court—has ruled that death induced by physicians is an inherently or predominately beneficial procedure to which all must have access as a right. It is a complex practice that the court ruled should be permitted in exceptional circumstances as a carefully crafted exemption to a crucial Criminal Code prohibition.

In fact, the opposite is true. Singling out disabled persons—and, soon, also persons with mental illness whose disease cannot be determined to be irremediable—exposes disabled persons already subject to systemic discrimination to a serious risk of death. This also threatens their right to life. It attaches the highest possible discriminatory stigma to what it means to have mental illness and to be disabled: namely, that our system offers them death rather than sufficient support, while it continues to protect others.

Second, before this committee, some medical experts insist we need to offer MAID for mental illness as a "constitutional right", while they hesitate when asked whether we can do so safely and whether irremediability can be determined in individual cases. That, I would put forward, is a caricature of how cautious policy and law-making should work. Medical, policy and ethics experts must inform government, MPs and the courts of what MAID expansion will mean. With Canada's MAID policy, this has been turned upside down: Parroting constitutional rights rhetoric, government has given some with a prior vested commitment privileged positions to implement it.

It is striking that those who now reassure us that concerns are unwarranted claimed from day one that MAID for mental illness was unproblematic and should not be treated differently, yet they were given authority to evaluate if other safeguards were needed, and then failed to recommend them, which leaves it up to the discretion of individual professionals whether people will live or die. Authorities didn't even reach out to the broader mental health community when a patient advocate and bioethicist resigned in protest from the expert panel on MAID and mental illness. It is further troubling, as one submission highlights, that some of the same experts have recently provided misleading information to MPs when the recent bill aimed at suspending the expansion went up for a vote in Parliament.

Third, the claim that we need only a few psychiatrists willing to do this because few patients will qualify is wrong; instead of reassuring, it is concerning.

First, in Belgium and the Netherlands, the practice remains controversial in part because a few psychiatrists have driven the practice in problematic directions. A criminal prosecution temporarily stalled expansion in Belgium, where one psychiatrist was involved in nearly half of the mental health euthanasia cases from 2007 to 2011. In those countries, physicians must agree that there are no other options left. Approval rates for psychiatric euthanasia are low—5% to 10%—mostly because of lack of irremediability, but when euthanasia for mental illness became more broadly practised, demand for it increased steeply, from 500 in 2008 to 1,100 in 2015. Demand in Canada will be higher, and no legal constraint will keep the approvals low.

● (1850)

When regulators state they are ready, we need to ask, "For what?" Yes, there will be flimsy regulations with rules that leave so much discretion that there will be little basis for criminal prosecution or professional discipline. Our law and professional rules will offer a largely open-ended licence to end the lives of mentally ill patients. This is an egregious form of discriminatory abandonment of mentally ill Canadians and their families.

[*Translation*]

I urge you not to hide behind a rhetoric of a constitutional right to let this expansion go forward.

[*English*]

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

Lastly, we have Ms. Voisin.

You have the floor for five minutes.

Ms. Jocelyne Voisin (Assistant Deputy Minister, Strategic Policy Branch, Department of Health): Thank you, chairs and members, for inviting us here today.

I want to thank the committee for their work and commitment on this issue so far, and continuing.

[*Translation*]

I would like to start out by saying that Health Canada believes that Canadians deserve to live in comfort and dignity, with access to care, including end-of-life care, that is appropriate to their needs and that respects their wishes.

[*English*]

We also recognize that MAID is a deeply personal choice, and we are committed to ensuring our laws reflect Canadians' evolving needs, protect those who may be vulnerable, and support autonomy and freedom of choice.

The federal Criminal Code of Canada permits MAID to take place only under very specific circumstances and rules, as you know. Anyone requesting MAID must meet stringent eligibility criteria to receive medical assistance in dying. Also, any medical practitioner who administers an assisted death to someone must satisfy all the safeguards first.

[*Translation*]

Given your mandate, I appreciate that your focus is on the system's preparedness to offer medical assistance in dying to persons with mental illness as the sole underlying medical condition.

[*English*]

As part of our work to prepare for the lifting of the exclusion for MAID eligibility for persons suffering solely from mental illness, Health Canada has been working closely with provinces and territories, as well as stakeholders in the mental health sector, health professional associations and others to address the recommendations of this committee and those of the expert panel on MAID and mental illness.

For instance, Health Canada supported the development by experts and release of a model practice standard for MAID and a companion document, which is "Advice to the Profession". We also funded the Canadian Association of MAID Assessors and Providers, CAMAP, to develop and deliver a nationally accredited, bilingual MAID curriculum. Registration continues to grow with, at last count, 901 registrants as of November 17. Of these, 490 are physicians, 132 are psychiatrists and 279 are nurse practitioners. The curriculum includes seven modules, including a module on mental illness as a sole underlying condition.

We also have enhanced our existing data collection on MAID through the federal monitoring system to help determine the presence of any inequalities or disadvantages in requests for the delivery of MAID. We continue to engage with indigenous peoples, as requested and recommended by this committee, through both indigenous-led and government-led activities, which will culminate in a "What We Heard" report in 2025.

Finally, to support case review and oversight, we are working with the provinces and territories to enhance consistency and opportunities to share best practices on oversight mechanisms that exist in those jurisdictions.

[*Translation*]

These resources will provide enhanced support for both the assessment and provision of MAID in situations where death is not reasonably foreseeable, such as Parkinson's, as well as in situations where the request is based solely on a mental illness.

At the federal level, we have been working diligently to ensure that the tools and resources are in place to support clinicians and regulators before March 2024. I know from my engagement with my provincial and territorial colleagues that they are working hard to prepare their health care systems in the lead-up to the lifting of the restriction. Many MAID assessors are already dealing with track two cases, where death is not reasonably foreseeable, which includes people who may have a mental illness combined with other conditions.

[*English*]

That being said, the level of preparedness does vary across the country, and some provinces and territories have noted concerns, most notably with regard to ensuring enough trained professionals, especially with mental health expertise.

For assessment of track two cases, practitioners have told us that these requests are generally more complex and challenging, because of the complexity of the conditions involved and the application of the existing rigorous eligibility criteria and procedural safeguards. This means that clinicians assessing MAID are spending much more time gathering the necessary information about the person and their condition. The process often involves a review of many years of treatments, surgeries and/or medications and consultations with experts in order to exercise due diligence and make a decision about eligibility.

● (1855)

The typical underlying medical conditions cited in track two are neurological diseases such as Parkinson's disease or multiple sclerosis. We know from the latest annual report in 2022 that track two cases made up only a very small proportion of MAID requests. There were 463 MAID provisions under track two, which represented 3.5% of the total number of MAID provisions and fewer than 0.2% of all deaths in Canada. In 2021, a partial year, 223 individuals with track two requests received MAID, representing only 0.07% of all deaths in Canada.

[*Translation*]

Again, I want to recognize the important work done by this committee to date.

[*English*]

Your reports have provided valuable insights into the views of various stakeholders, and federal officials have worked closely with provinces, territories and key stakeholders in the MAID community to continue to use these recommendations to support the improvements in the delivery of MAID across Canada.

Thank you.

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

We will go into the first round of questions from the members of Parliament, beginning with Mr. Fast for five minutes.

Hon. Ed Fast (Abbotsford, CPC): Thank you, Madam Chair.

My questions will be directed to Professor Lemmens.

Professor, today you have heard again here at committee the suggestion that the law in Canada compels parliamentarians to introduce MAID for the mentally ill. We heard that also from Ms. Shelley Birenbaum at our last meeting. She said that she represented the CBA, the Canadian Bar Association, and she suggested that there was "a strong charter vulnerability" if Canada did not expand MAID to include the mentally ill.

Do you agree with that assessment, that we face a strong charter vulnerability if we don't expand MAID?

Dr. Trudo Lemmens: I fundamentally disagree, and I'm not the only one who disagrees with that. I think many legal scholars and many people in the legal profession disagree. I think it reflects a distorted view of MAID as a quasi inherently beneficial practice, as if not having facilitated access within the medical system to it is a greater harm than death.

I think that discriminatory analysis, on the contrary, would focus on existing structural discriminations of persons with disability, particularly what persons with mental illness already face, and the second component is the high risk to women, indigenous persons and persons living in poverty. I would argue, on the contrary, that adding easier access to death to existing inequality while we continue to protect others against premature death...because we have to emphasize that it's still in the Criminal Code. It still protects others, but we will now exclude that.

Hon. Ed Fast: Thank you.

I want to be very specific. Is there anything in Carter, Truchon or the Alberta EF decision that would compel Parliament to offer MAID to the mentally ill?

Dr. Trudo Lemmens: I urge parliamentary committee members to look at the submissions they received. We submitted something.

I think there is nothing in Carter, certainly not in Carter, that explicitly states that we have to legalize it. In fact, the Supreme Court explicitly excluded mental illness from its reasons.

Hon. Ed Fast: Are there sufficient legal and procedural safeguards in place to safely implement MAID for the mentally ill?

Dr. Trudo Lemmens: In my view, there are not. I think the safeguards that we have are easily circumvented. They are already circumvented in the context of track two. I would urge committee members to watch, for example, the recent documentary by Al Jazeera, where we see Rosina Kamis receiving MAID in the context of track two. In my view, it shows that you can drive a truck through some of the requirements that are supposedly protecting people from receiving track two MAID.

I look at the practice guidelines at the CAMAP, educational documents that have been prepared, the model practice standard and the guidelines. I see an overwhelming emphasis on the need to provide access to MAID, even to such an extent that, for example, in the CAMAP documents, there is an explanation of how you can easily turn track two MAID into a track one MAID. In other words, even if you're assessed on track two.... For example, the CAMAP document states specifically that by refusing antibiotics for a serious infection, you can turn your track two into a track one.

I would say that, for me, this is symbolic of the way our regulatory approach has been in the context of track two, and this will apply to the context of mental illness.

● (1900)

Hon. Ed Fast: In your brief, you said that a fresh constitutional analysis is indicated and a higher degree of deference is owed.

What do you mean by “a higher degree of deference”?

The Joint Chair (Hon. Yonah Martin): Answer very briefly, Professor Lemmens.

Dr. Trudo Lemmens: I think this is very well established by leading constitutional scholars. I would even refer to the statements by the late Professor Hogg, who explicitly changed his opinion. He indicated, in a more recent publication, that Parliament was given leeway to develop a detailed regulatory regime and that the courts have to assess that regulatory regime, respecting the law-making of Parliament under a strict separation of powers.

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

Next, we'll go to Mr. Scarpaleggia for five minutes.

Mr. Francis Scarpaleggia (Lac-Saint-Louis, Lib.): Thank you very much.

It is very humbling to be on this committee. Many of the members were on the committee before me and know much more about this than I do. The witnesses, of course, are incredibly qualified.

By way of background, I'm trying to go back two years, when the Senate amended Bill C-7 to remove the mental illness prohibition. It sent the legislation back. Did it add the need for an expert committee, or did the government add that? I should probably know that myself, but it's been a couple of years.

Dr. Jocelyn Downie: The expert committee review is embedded in the legislation.

Mr. Francis Scarpaleggia: Was it embedded in the Senate amendment?

Dr. Jocelyn Downie: I'm not sure whether it came from the Senate or whether it was in the original bill. It was certainly in Bill C-7.

Mr. Francis Scarpaleggia: It was, but I'm thinking maybe the government put that in, and the Senate just carved out the prohibition. The Senate sent it back without any kind of safeguard process in their amendment. That's interesting.

I'd like to talk about the issue of irremediability. That's central, because it defines, in a way—as I understand it—why MAID is allowed. It's because something is “grievous and irremediable”. When it comes to severe mental illness, there seems to be a lot of uncertainty around whether one can determine if a condition is irremediable. I'm sure you read the Globe and Mail editorial last month. It said, “One prominent study found that trained and experienced clinicians correctly predicted a patient's chance of long-term recovery in just 47 per cent of cases, fewer than if they had simply flipped a coin.”

Could the lack of certainty around irremediability become a justifiable section 1 defence?

Dr. Jocelyn Downie: No, I don't believe so.

One thing we have to pay close attention to is the fact that "grievous and irremediable" is in the law—it's not a clinical term—and "serious and incurable illness, disease or disability" is in the law. It is, in fact, part of the definition of "irremediability". When people talk about not having a clinical definition, that's inappropriate, because we're not looking for a clinical definition of a legal term. Legal terms from the statutes should be defined in the statutes—and they are. What happens is that clinicians have to determine whether that definition is met. That's where you develop practice standards, and that's what we have. In the model practice standard, there's a clear statement about "serious and incurable illness" and so on, so you wouldn't be able to show it was missing.

The other thing I'd add is this. Of course, "natural death" becoming "reasonably foreseeable" is in the Criminal Code. There isn't consensus among clinicians—there certainly wasn't when it first came out—about what this means.

It's not a justification for violating the rights.

● (1905)

Mr. Francis Scarpaleggia: They made the argument here in the editorial that when it comes to an illness like cancer, it's true that foreseeability is not 100% certain, but it's much more so than in the case of mental illness.

Going back to the point you raised about the definition of "irremediability" in law, could you explain the difference between that definition and the notion of irremediability in the clinician's opinion?

Dr. Jocelyn Downie: One thing clinicians will tell you is that the term "irremediable" is foreign to them. It's not even a clinical term. They recognize "incurable". When you have certain kinds of conditions—not just mental disorders—the conventional understanding of "incurable"—there is no cure—is not available. The lack of consensus around what "incurable" means is not specific to mental disorders. Again, it doesn't work as a justification for singling out mental disorders.

The other thing I would say, in relation to that Globe editorial, is that a group of psychiatrists published a response to it, because it was full of misinformation. I invite the committee to review that response.

Mr. Francis Scarpaleggia: That's interesting.

The Joint Chair (Hon. Yonah Martin): You have 15 seconds remaining.

Mr. Francis Scarpaleggia: I don't think I have time to weave an argument or any kind of question, so I'll let it go.

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

Next we'll go to Monsieur Thériault for five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

It is difficult for me to follow the interpretation when my colleagues are commenting out loud. So I call for calm and serenity while we are talking about medical assistance in dying.

Ms. Downie, you sent us a short text where you said that the Carter decision and the Baudouin ruling did not exclude mental disorders.

Can you tell us more about that and explain why that is the case? Earlier, we were told that the Carter decision did not allow using a mental disorder as the sole medical condition for obtaining medical assistance in dying. You also said that the Baudouin ruling, among others, rejected the general exclusion based on membership in a group, such as vulnerable persons. I don't know if you remember.

Can you explain to us how the Carter decision would be unconstitutional if it was decided to give people with mental disorders access to medical assistance in dying?

[*English*]

Dr. Jocelyn Downie: The key is to look back at Carter and recognize that the declaration was that if you create a barrier to access for people who have a grievous and irremediable medical condition causing enduring and intolerable suffering, that is unconstitutional. They did not say that mental disorders are not a part of grievous and irremediable medical conditions. They did not exclude them. They could have. They would have, had they wanted to.

That's the analysis. Mental disorders are grievous and irremediable medical conditions. Therefore, it would be against the Carter declaration if you had a barrier to access for people with mental disorders.

The other thing is that it is worth looking at the decision. I knew this issue would come up today, because it always does. The EF decision is very clear. As it can be seen in Carter 2015, the issue of whether psychiatric conditions should be excluded from the declaration of invalidity was squarely before the court. Nevertheless, the court declined to make an express exclusion as part of its carefully crafted criteria. You had a circle, and it didn't carve it out.

The other thing I would add is that we also had the G decision, which is important for us to remember now, from the Supreme Court of Canada. It helps us here because it shows that you can't do a group-based exclusion. You must do a case-by-case assessment. There's nobody saying that there aren't some complex cases, but we have to do them case by case.

[*Translation*]

Mr. Luc Thériault: Thank you.

Mr. Scarpaleggia brought up the clinical differences between cancer and the predictability of a mental disorder. Earlier, you talked about the expert panel report. Does that report not provide additional safeguards that further frame the expansion of access to medical assistance in dying to persons with a mental disorder? I am thinking, for example, of the obligation to provide prospective oversight, which is currently not found anywhere in Canada in the implementation of medical assistance in dying. It's retrospective. I am also thinking of the obligation to obtain the opinion of a second psychiatrist, who must be independent of the care team.

Are there no safeguards within that? I would like you to tell me about those safeguards. We are prepared to go all the way to the Supreme Court, if necessary, and the Supreme Court will have to determine whether this expansion is reasonable or not and say what safeguards are necessary to ensure the safe use of medical assistance in dying, if we do not want to go down the so-called slippery slope.

What additional arguments or safeguards do you think this expert report provides in order to expand access to medical assistance in dying to persons with a mental disorder?

● (1910)

[*English*]

The Joint Chair (Hon. Yonah Martin): You have about 40 seconds.

Dr. Jocelyn Downie: I'd actually answer with a structural point, which is that we have the Criminal Code and then we have the colleges of physicians and surgeons and the colleges of nurses. We have practice standards. You should not get into the weeds of the kinds of things like which specialist you need to see as your third person. That's not how the Criminal Code works. It should be in practice standards, and that's what's in those practice standards. It's advice about how you bring up MAID, when you should have to see a consultant and whether the consultant should have to be a psychiatrist. We actually took the position that they shouldn't have to be, because in fact they might be a specialist in something else that's more relevant.

It's a structural response, which is that the safeguards are appropriate in the Criminal Code now. As we build out the protections, they are in the practice standards and then they become clinical protocols.

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

Next, we'll go to Mr. MacGregor for five minutes.

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

Thank you to all of our witnesses for helping to guide our committee through this. It's not an easy subject, and I say that with experience, having been on this committee from the get-go, both in the last Parliament and in this one.

Dr. Downie, I'd like to start with you.

I'll freely admit that, personally, I do have a level of discomfort when we talk about mental disorders and access to MAID. I also appreciate that our committee's mandate is quite narrow. We're not tasked with relitigating the law. In fact, the House of Commons just had a vote on that, so we have to respect that process. We're being tasked as a committee with verifying the degree of preparedness, and I did listen to your opening remarks. I'll tell you why I have a level of discomfort.

I represent the riding of Cowichan—Malahat—Langford on Vancouver Island. I walk around my communities, and it is quite obvious that there is a mental health crisis going on. You can see people in obvious need of help who are not getting the services they require. It's tearing parts of my community apart.

As a parliamentarian—not only as a member of this committee, but also as someone who is trying to do right by his constituents—how do I verify the degree of preparedness? How do I satisfy that when I have that reality at home?

Dr. Jocelyn Downie: I think one of the things you could do is to ensure that the lack of supports and services is not driving requests for MAID—and it is not. We have good, solid evidence from the other permissive jurisdictions over the years, and we now have good data from Canada as well that it is not what's driving requests for MAID.

Then, what you do is say that, okay, both of those things are incredibly important. We need to protect the rights the Supreme Court of Canada acknowledged, and it set out the parameters in Carter. We need, in parallel, to promote supports and services for people with mental disorders, all the various things that bring about socioeconomic vulnerability.

Parliament has an obligation to do those two things at the same time. Don't hold individuals' rights hostage to Parliament's failure to promote mental health supports and services, and disability supports and services. Do both of them. I think it's your responsibility to do both at the same time. When you're answering your constituents, you need to be able to tell them those are not the drivers of MAID.

People getting MAID are actually very privileged. They're white. They're well off. They're highly educated. They're not in institutions. They have families. The picture is one of privilege. That doesn't mean we don't want to look after the people who are vulnerable.

● (1915)

Mr. Alistair MacGregor: Thank you.

I have only a couple of minutes left. Ms. Voisin, I'd like to turn to you.

My riding has a large indigenous population. Many of the elders are living with their past experiences at residential schools. Again, the level of support in that community leaves a lot to be desired.

I know Health Canada has been engaging with indigenous peoples on MAID. Has the subject of mental disorders been part of that, and is there anything you can report to this committee based on that process?

Ms. Jocelyne Voisin: In terms of our indigenous engagement on MAID, we have been engaging specifically with those communities on a distinction-based approach. We have an online survey, and we have also provided funding to some organizations to engage with their communities directly.

What we've heard so far is that it's really important to take the cultural context into play when talking about MAID, that they—

Mr. Alistair MacGregor: I'm sorry to interrupt, but on the specifics of a mental disorder and accessing MAID, has that been part of the...? That's what I want to focus on.

Ms. Jocelyne Voisin: I don't think we have any.... A few people have raised the issue of mental illness in the context of MAID, but it hasn't.... The consultation has been broader than that. It hasn't been focused on that issue specifically. We don't have a large amount of data to provide on how indigenous people feel about that particular issue.

Mr. Alistair MacGregor: Very quickly, because I'm running out of time, do you foresee any special requirements that you're going to have to put in place for the tracking of the data? Will mental disorders need a special type of analysis of the data apart from what we already have?

The Joint Chair (Hon. Yonah Martin): Be very brief.

Ms. Jocelyne Voisin: We are collecting more data now, including for indigenous populations, in terms of MAID. Our next annual report should have more available data, which will give us a better disaggregated view of how MAID is being provisioned across the country.

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Voisin.

The next questions will be from the senators.

We will start with Senator Mégie.

Senator Mégie, you have three minutes.

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

My question is for Ms. Downie and Ms. Voisin.

Generally speaking, people are uneasy, even those around the table. There seems to be a sense that making MAID available to people with mental health issues is like having an open bar that everyone can take advantage of.

However, one of the witnesses we heard from was a psychiatrist who said that she had seen only three patients in her 35-year career who would be eligible for MAID, given the serious criteria for assessing chronicity, long-term medications and so forth.

That means that a person in crisis could not receive MAID, and two other witnesses confirmed that.

You said that there weren't enough clinicians to do the assessments. Is that going to be a problem? If it takes a clinician 35 years to identify three eligible patients, does that mean we would need 100 psychiatrists?

The floor is yours.

[*English*]

Ms. Jocelyne Voisin: Maybe I'll go first, and then turn to Dr. Downie. I think we would agree with those statements. Just because you make people with a mental illness eligible.... The assessors, right now, are evaluating many track two cases that involve people who have a mental illness in combination with other conditions. This is not something new. Those are complex cases. As Dr. Downie was saying, there's a requirement to consult with experts, depending on the case and depending on what condition is at issue.

Just because you have a mental illness, that does not mean you are suddenly eligible for MAID. It's a very high bar in terms of eligibility.

● (1920)

[*Translation*]

Hon. Marie-Françoise Mégie: Go ahead, Ms. Downie.

[*English*]

Dr. Jocelyn Downie: I would echo all of that. We are going to have some requests, and we will have very few people who will be eligible. We will have sufficient clinicians who are able to provide it, either as assessors and providers or as playing the consultancy role.

I also want to emphasize that if nobody is available...because this came up maybe two weeks ago. If a clinician isn't available to act as an expert consultant, the person can't get MAID. It's not like an absence of the experts would mean that people are getting MAID without that protection, because it would be illegal to proceed with MAID without that consultation. There's a protection built right in.

The Joint Chair (Mr. René Arseneault): Thank you, Professor Downie.

[*Translation*]

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

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Mégie.

Next, we go to Senator Wallin.

[*English*]

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

For the record, the Senate did call for some safeguards on this question, and the government elaborated on that when it was sent over.

I'd like to hear from all three, because we have different.... When we talk about hiding behind the Constitution, that troubles me. Presumably, we want our laws and services to be constitutional and to be accessible. Because we have not heard from the Department of Justice, maybe we'll start here and go in that direction.

Ms. Myriam Wills (Counsel, Criminal Law Policy Section, Department of Justice): I'll start off by stating the obvious. There are very diverging views on this topic. No court has ruled on whether or not the charter requires MAID for mental illness. If we look at the charter statements in former Bill C-7 and former Bill C-39, they set out the charter considerations supporting the charter consistency of both prohibiting MAID for mental illness and permitting MAID for mental illness.

Hon. Pamela Wallin: We want laws to be constitutional. We spend a lot of time on that in the Senate when we get bills from the other side.

Ms. Voisin, go ahead.

Ms. Jocelyne Voisin: From the Health Canada perspective, we need to respect the jurisdiction of the provinces and territories in terms of actually managing the health care system. In terms of how we are managing this file, we leave it to the provincial bodies, the regulatory bodies that have the oversight of medical professionals. We are working very closely with the provinces and territories to do what we can to support them in developing and putting into regulation practice standards.

Dr. Jocelyn Downie: Respecting charter rights is the highest obligation of members of the House and members of the Senate, so you should never pass legislation that you do not have confidence is consistent with the charter and consistent with the Constitution—the division of powers as well as the charter.

Hon. Pamela Wallin: You raised another point, Dr. Downie, that the lack of political preparedness or willingness of governments to embrace this is not a reason to deny section 7 or section 15 rights. Are you getting a sense that may be an issue?

Dr. Jocelyn Downie: Absolutely. I think that if you look at the arguments, that's all that's left. There's no solid evidence and there are no valid arguments that justify a further delay. Therefore, the only explanation is political.

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Wallin.

[*Translation*]

We will now hear from Senator Ravalia, who is filling in for Senator Kutcher. You have three minutes, Senator.

[*English*]

Hon. Stanley Kutcher (Senator, Nova Scotia, ISG): Thank you, Chair.

Thank you to all witnesses.

My question is for Ms. Voisin.

In your dialogue with territorial and provincial partners, from the readiness perspective, do you feel that the medical education programs that have been established as a foundational element for clinicians practising MAID have afforded enough knowledge, from the mental health perspective, to create a milieu that will ensure there is safety and annul what we would consider bogus requests?

Ms. Jocelyne Voisin: Yes. As I said in my remarks, the curriculum includes seven modules, and one is focused on mental illness. It combines both an online learning component, which discusses the many challenges that are inherent in making a decision or an assessment related to mental illness, and case reviews, including mental disorders that are anticipated to be most commonly found in terms of those assessments. There's even group-facilitated discussion. There's a very comprehensive module on mental illness.

As Dr. Downie said, we've also done knowledge exchange workshops with experts, and we're getting more and more registrations for the curriculum, so I think that preparedness is growing. With my PT colleagues, my provincial and territorial colleagues, we're discussing the next steps in terms of more detailed clinical guidelines, oversight mechanisms and how we can really share those best practices and make sure there is consistency across the country.

● (1925)

Hon. Stanley Kutcher: To follow up, Dr. Downie, do you feel that we've built in sufficient safety precautions in the assessment of those who are mentally ill who would be seeking this pathway?

Dr. Jocelyn Downie: Yes, I think so. It's in the Criminal Code, and then it's in the model practice standard, which is being reproduced in the practice standards across the country, and then you have the curriculum.

I would also add that the people who are going to be doing the first sets of MAID for mental disorders as a sole underlying condition are not going to be new MAID providers, but very experienced MAID providers. We have psychiatrists across the country who have been engaged in MAID assessments and provision and also acting as consultants. Those are the ones who are going to be doing it. They are very experienced and very knowledgeable. They have decades of experience in psychiatry and years now in working with MAID, so we have the experts and we have training for the people coming up through, who will then be mentored by the experts. Yes, I think we are well established.

Hon. Stanley Kutcher: Thank you.

Hon. Mohamed-Iqbal Ravalia: I will just make a final point. I'm speaking as a clinician with 35-plus years of experience in a rural and remote community dealing with very complex mental health issues. In my practice, as I've perhaps said, are two individuals who might have met this. These are individuals who have had psychiatric care, electroconvulsive therapy, cranial magnetic stimulation, deep brain therapy, a variety of therapies. They failed all of that and live a lonely, dark existence, so let's not forget those individuals.

The Joint Chair (Mr. René Arseneault): Thank you, Mr. Ravalia.

[*Translation*]

Go ahead, Mr. Dalphond.

Hon. Pierre Dalphond (Senator, Quebec (De Lorimier), PSG): Thank you, Mr. Chair.

I have a minor clarification. The Senate proposed imposing an 18-month time limit on the MAID eligibility exclusion for individuals whose mental health was the sole underlying medical condition. The House of Commons extended that period to 24 months and proposed other provisions. [*Inaudible—Editor*] is therefore in place. The purpose of the proposed 18-month time limit was to establish a safeguard system for people. The report was very clear.

My question is about the committee's mandate as it relates to upholding the Constitution. We amended the Criminal Code, and the provisions we put in place were very clear. From Professor Downie's comments, the provisions seem to be quite satisfactory. The committee's mandate is not to review them, but to make sure that they are clearly understood and will be implemented.

I take from your opening remarks, Ms. Downie, that we are doing more than we need to because implementation falls on the provinces, not the federal government. We want to make sure that the provinces are doing what they are supposed to, but our constitutional duty doesn't go that far. Is that correct?

[*English*]

That's for you and maybe Ms. Wills.

Dr. Jocelyn Downie: I'll jump in first.

No, it absolutely doesn't. The federal government has done more in respect of this aspect of MAID than it has for any other aspect of MAID in relation to the provincial/territorial jurisdiction. The curriculum or the medical education, the knowledge exchange workshops, the medical training and the model practice standard are all done at a provincial/territorial level. The federal government has facilitated all of that, which has been extraordinary.

The fact that we don't have it for other things is maybe a point we should take: Look at how this can be done. Look at how good it is when we work together. We can build something like this and get a harmonized system across the country.

Ms. Myriam Wills: I guess I would say that all government legislation like Bill C-7, which expanded MAID for cases where death is not reasonably foreseeable, includes a charter statement. The Department of Justice and the minister must satisfy themselves that whatever is being proposed is constitutional.

Hon. Pierre Dalphond: Yes, but this is not really the issue behind my question. My question is more this: Have we done that by amending the Criminal Code the way we have? I think we have. If we have done so, then what we're doing now is more than what is constitutionally required. We are testing the water. We're making sure everything is going to happen as we think it should be happening.

We're not constitutionally bound to do that, but I believe we're going beyond that to reassure Canadians.

● (1930)

Ms. Myriam Wills: Just to make sure I understand the question, it's about whether the safeguards in the Criminal Code are sufficient to protect—

Hon. Pierre Dalphond: Yes.

Ms. Myriam Wills: I think that is ultimately up to Parliament to decide. I can't speak to any advice that's been provided to the government on—

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Willis.

[*English*]

Madame Martin, the floor is yours for three minutes.

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

I just wanted to say that I do share the concerns of Mr. MacGregor about the lack of consultation with indigenous communities. You said that you have done some broad consultation, but nothing specific to MAID and mental disorder. We heard testimony previously from some of the members of the indigenous community that there has been quite an absence of consultation. That is quite concerning to me.

Professor Lemmens, I'm aware that you have recently been a member of an expert panel for the Jersey government that made recommendations about assisted dying legalization options. I have two questions. Were any of the committee findings and legislative options informed by Canadian MAID law and practice? Was there any discussion about MAID and mental illness?

Dr. Trudo Lemmens: Thank you for the question.

I should say that we were not mandated to discuss the rationale for legalization. Jersey put forward two options for legalization. One was a terminal illness diagnosis, kind of styled track one but narrower than in the Canadian context. The second one was a very broad track, which compares with the Canadian track two. I was not completely surprised, but I was happily surprised, to see that my two colleagues, who actually are for the legalization of assisted dying in some form, agreed, looking at the evidence, that the Canadian model was not the approach they should be taking.

We actually recommended against an open-ended access to MAID for unbearable suffering. Psychiatric MAID is explicitly excluded, as it is in most jurisdictions around the world, or in many jurisdictions around the world that have legalized some form of assisted dying. Simply, this is also because most jurisdictions limit access to MAID or euthanasia or assisted suicide in the end-of-life context to people who have a terminal illness diagnosis, where mental illness would not fulfill the criteria of a clearly identifiable survival prognosis or terminal illness prognosis.

The Joint Chair (Hon. Yonah Martin): You mentioned both Belgian and Dutch euthanasia regimes in your remarks. Do you have more concerns about MAID for mental illness in Canada than those other regimes?

Dr. Trudo Lemmens: I think people have to realize that the fundamental difference between the Canadian system and Belgium and the Netherlands is that we don't even have an obligation that physicians have to agree that all reasonable treatment options are fulfilled. People are saying, oh, there will be only a few cases. It is practised more broadly already than in a few cases in Belgium and the Netherlands. It will be practised much more broadly in the Canadian context because of individual choice—

The Joint Chair (Mr. René Arseneault): Thanks, Professor Lemmens. I'm sorry, but we're so tight.

[*Translation*]

We won't have time for a second round during this first hour, so we will suspend briefly to let the witnesses take their leave and bring in our panel for the second hour.

Thank you to the witnesses, Ms. Willis, Ms. Voisin, Ms. Downie and Mr. Lemmens.

● (1930)

(Pause)

● (1935)

The Joint Chair (Mr. René Arseneault): We are now beginning the second hour of today's meeting. Please take your seats.

Welcome to the witnesses, who are all joining us remotely. During the second hour, we have with us, as an individual, Dr. Stefanie Green, MAID practitioner and adviser to the British Columbia Ministry of Health; Julie Campbell, nurse practitioner, Canadian Association of MAiD Assessors and Providers; and Dr. Gordon Gubitz, division of neurology, department of medicine, Nova Scotia Health.

We are really pressed for time today, so you will each have five minutes to give your opening statements.

We will start with you, Dr. Green.

● (1940)

[*English*]

You have the floor for five minutes. It's very tight.

The floor is yours.

Dr. Stefanie Green (President, MAID Practitioner, Advisor to BC Ministry of Health, As an Individual): Thank you for this opportunity.

My name is Stefanie Green, and I'm a physician with 30 years of clinical experience.

In June 2016, I began working almost exclusively in assisted dying. You may read of my credentials in my written brief. I've no personal or professional stake in the outcome of your deliberations, but I remain committed to providing the highest standard of medical care possible under any and all legislation.

If the purpose of this committee is "to verify the degree of preparedness attained for a safe and adequate application of MAID" in MD-SUMC situations, your work should not be complicated. Clearly, there is a high degree of preparedness. I point your attention to the numerous readiness activities plainly outlined in the written brief of CAMAP, and those referenced by Dr. Mona Gupta and Dr. Douglas Grant, and tonight by Professor Downie.

There is readiness at the federal level. There is stated preparedness by the medical and nursing regulatory bodies, as well as by professional associations. Clinical teams in British Columbia, Alberta, Saskatchewan, Ontario and Nova Scotia have all confirmed their readiness. I can speak more to this in our discussion if you wish.

Regardless of what this committee ultimately recommends, I am most concerned that it be based on fact and not on any fundamental misunderstanding. I submit the following three points of information for clarity.

Number one, consensus is not and has never been required in the development of medical practice. There's no consensus on many medical practices—hormone replacement therapy for women, safe injection sites, use of ketamine for treatment-resistant depression. This lack of consensus is not taken as a reason or justification to prohibit these practices. There is no consensus among clinicians about MAID itself, yet that did not and does not stop MAID from being permitted under the law.

Medical practice does not start with training all clinicians before the practice is permitted; rather, it starts with training some, who then train others over time. Only clinicians with the professional competence to provide the intervention are permitted to do so, by the standards already published and already enforced by the colleges of physicians and surgeons or colleges of nurses in every province and territory.

Any suggestion that consensus is required before moving forward with MD-SUMC is opposition to MAID disguising itself as a benchmark.

Number two, legislation is clear regarding MAID eligibility. We need to stop focusing our attention on a person's diagnosis, mental disorder or otherwise, and look to the eligibility criteria—the condition must be incurable, irreversible, unrelievable.

Clinical understanding and implementation of MAID legislation continues to evolve and mature. The recently published model practice standard for MAID has contributed significantly to this understanding.

As an experienced MAID practitioner and as one who teaches others how to approach this practice, I would state as clearly as possible for your recognition that in situations of MD-SUMC, someone in crisis is not eligible for MAID. Someone who is newly diagnosed is not eligible for MAID. Someone who hasn't had treatment, or refuses all treatments with no rationale, or is seeking MAID due to socio-economic vulnerabilities is not eligible for MAID.

Number three, we have enough psychiatrists already involved to move forward. Legislation requires two independent clinicians to find a patient eligible before they can proceed. For patients whose natural death is not reasonably foreseeable, a clinician with expertise in the condition causing the person's suffering must also be involved.

Psychiatrists may therefore potentially play two different roles: they may be assessors or providers of MAID, although few will be required for this role, or they may be consulted as clinicians with experience in the condition causing the person's suffering. Psychiatrists are already being consulted as clinicians with expertise in many applications, because they already possess the skills and training to be considered experts in their field. Canada has nearly 5,000 psychiatrists already adequately trained to continue to fulfill their role of expertise in MD-SUMC situations.

Over 100 psychiatrists have already registered their interest in becoming involved in MD-SUMC. This represents 2% of all psychiatrists in Canada. Last year, about 2% of all physicians in Canada provided 13,000 MAID procedures. I would suggest that 2% of our psychiatrists are sufficient to consult on what is rationally expected to be significantly fewer MD-SUMC cases.

Preparedness for MD-SUMC is clear. Please do not let misinformation distract or cloud your deliberations on this point.

Thank you.

● (1945)

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Green.

Now we will hear from Ms. Julie Campbell.

The floor is yours for five minutes.

Ms. Julie Campbell (Nurse Practitioner, Canadian Association of MAiD Assessors and Providers): Thank you for inviting me here today.

My name is Julie Campbell. I'm a nurse practitioner and the vice-president of the Canadian Association of MAiD Assessors and Providers, or CAMAP. CAMAP represents professionals who work in the delivery of MAID in Canada. CAMAP does not take a position on MAID MD-SUMC. We are focused on, and committed to, supporting our members to provide the highest standard of medical care within the law.

As part of this commitment, CAMAP has, over the past two and a half years, developed the Canadian MAID curriculum, or CMC, the first comprehensive, nationally accredited, bilingual and evidence-based educational program to support the practice of MAID in Canada. It aims to educate new MAID practitioners, advance the skills of existing MAID practitioners, and help standardize the approach to care by supporting those who deliver MAID care from coast to coast. On August 21, 2023, the CMC was launched, and the enthusiastic response from clinicians exceeded expectations. Feedback from clinicians who have completed modules has indicated very positive responses when asked if they felt that their knowledge and confidence had increased.

In addition to expertise in MAID assessment and provision, CAMAP members also carry a variety of clinical expertise in many areas, including psychiatry. Our members rely on colleagues who act as consultants in their area of expertise. When an assessment is completed for a patient without a reasonably foreseeable natural death, and for whom neither assessor has both expertise in MAID and expertise in the condition causing the patient's suffering, we rely on these consultants to provide their expertise in the condition to add to the assessors' expertise in MAID assessment.

The difference between the role of assessor and the role of consultant is important to understand. Our psychiatrist colleagues have, by virtue of their extensive training and expertise as psychiatrists, advanced knowledge on capacity decisions and mental disorders. We have utilized their skills as consultants for any patient who requires it. This is not specific to patients with MD-SUMC, and it may apply to both patients with and without a reasonably foreseeable natural death. For patients with MD-SUMC, we will utilize their skills once again.

In Canada, there are approximately 5,000 psychiatrists who, by virtue of their education and skill, may act in the role of a consultant. Included in that, there are psychiatrists who have sought and obtained expertise in MAID assessment. To date, more than 100 psychiatrists have begun or completed training with the CMC, demonstrating a significant level of interest of this subset of psychiatrists, who will then both be a source of expertise from their respective backgrounds and have expertise as assessors.

Since 2016, we have safely assessed patients requesting MAID who also had comorbid mental disorders. Part of our thorough, thoughtful, and safe approach to eligibility assessment has always been to see the patient as a whole. To help our members, we have developed clinical guidance documents such as “Assessment for Capacity to give Informed Consent for Medical Assistance in Dying (MAiD)” and “Medical Assistance in Dying (MAiD) Assessments for People with Complex Chronic Conditions”. These documents have helped guide our members to safely assess and provide for patients with complexities. They have helped us develop experience that will be relevant to assessing patients with requests for MAID MD-SUMC.

As is standard in medical practice, we are evolving each day, sharing our best practices and gaining experience, and we now have almost seven years of experience upon which to draw. We have organized and facilitated knowledge exchange workshops with representatives from across Canada. One knowledge exchange was focused on clinician readiness, and the other on system readiness, to ensure not only that the clinicians are ready, but that the other important members of our teams are also ready—namely, nurses, social workers and administrators, among others. We have hosted a three-part fall symposium with specific learning around assessing individuals with mental disorders. We hold monthly case-sharing webinars. We have prepared diligently for the expiration of the sunset clause, and we are ready.

CAMAP members are ready for the planned legislative change in March 2024 and will continue to provide compassionate and high-quality care to all patients considering MAID.

Thank you.

● (1950)

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Campbell.

Dr. Gubitz, please go ahead. You have five minutes.

[*English*]

Dr. Gordon Gubitz (Head, Division of Neurology, Department of Medicine, Dalhousie University and Nova Scotia Health Authority): Thank you, and good evening from Nova Scotia.

My name is Gord Gubitz, and I am very grateful to be able to speak to you today. I'm a professor of medicine and neurology at Dalhousie University. I became a MAID assessor and provider for both track one and track two patients after legislation was passed.

I'm also a board member for the Canadian Association of MAiD Assessors and Providers, and I sit on their education committee. I was the chair of the national group from CAMAP that developed the MAID curriculum you've heard about, which was discussed earlier. Hopefully we'll have a chance to discuss it in the question period.

I'm also the clinical lead for MAID in Nova Scotia. That involves working on a weekly basis with our administration in collaboration with the Department of Health to oversee MAID in our province.

I'm pleased to speak to you this evening on behalf of Nova Scotia as an example of jurisdictions across the country to help you understand why Nova Scotia stands ready to move forward with caring for people who request MAID for MD-SUMC, starting in March 2024.

Each province and each territory will deal with this differently. In Nova Scotia, we have one central team that is managed and overseen by a very strong administrative staff with skilled nurse navigators who triage and assess patients and provide detailed assessments and referrals. We also have full-time nurse practitioners who work geographically to help provide MAID. In the wake of Bill C-7 and in anticipation of the complexities of track two, we have recruited additional members to our team, including social workers, etc.

Our team is involved with regular education with learners across the province. Importantly, our team meets on a regular basis every week on Friday morning to review "challenging cases", as we call them. Many of these people have complicated medical problems and are often track two patients, many with underlying mental health issues.

With respect to MD-SUMC, we recognized that we would need to start to do this work some time ago, and have been working for over 18 months to ensure that Nova Scotia is ready. We created a provincial working group to develop policies and processes that would serve the MD-SUMC population. It was beneficial to have all of the national work that was done to help guide us.

Our plan was to be ready for the implementation by March 2023. To do this, we hired additional staff with mental health expertise. Thus, one of each of our nurse navigators, nurse practitioners and social workers has a clinical background in mental health. We're in the process of exploring psychology consultancy, and we are recruiting an MD-SUMC clinical lead in psychiatry. This person will hold a position similar to mine but with a focus on mental health. The two of us will work collaboratively with our MAID team, as our skill sets are similar and complementary.

Our working group was chaired by two psychiatrists, one of whom also does complex MAID assessments where capacity is an issue. The working group included members of our core MAID team, hospital and community-based psychiatrists, a specialist in addictions medicine, a bioethicist, a psychiatry resident and representation from our government. As the process moved forward, we included one of our social workers and a nurse navigator with mental health experience.

The working group was tasked with completing a detailed scoping review of the various topics relevant to MAID and MD-SUMC. It developed detailed and practically useful background material and guidance documents that will support clinicians in Nova Scotia in their day-to-day work. We also provided overall governmental recommendations.

To this point, we have an ethical framework that has been based on a systematic review of the emerging area of palliative psychiatry. We have detailed documentation and training materials for the required assessments, including a comprehensive process that focuses on determining capacity, voluntariness, irremediability and structural vulnerability, and understanding suicidality versus a reasoned wish to die. We also have clinical pathways, including a modified intake process that will be completed by the nurse navigator, specifically built for MD-SUMC.

We've followed along with a specific recommendation. One of the two MAID assessors in Nova Scotia must be either a psychiatrist or an addictions specialist, depending on the case.

We are engaged in a prospective review similar to our weekly complex case discussions. Thus, our track two discussions every Friday morning will increasingly begin to involve people with mental health as a sole underlying condition. We will also be undergoing retrospective case audits for each person who completes the process of MAID using a standardized process. We've developed post-intervention supports for clinicians, families and friends.

In conjunction with CAMAP, we are developing training programs, including the modules that have been described previously, and we're looking at compensation models. We have shared all of our documents with the other jurisdictions across the country, as Ms. Campbell outlined in the presentation that she gave. We have engaged in some really interesting provincial and territorial discussions.

Over the coming months—

● (1955)

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Gubitz. You can elaborate later on through the questions that will be asked of you.

[*Translation*]

We will now have questions from members of the various parties. They will each have five minutes.

Please go ahead, Mr. Cooper.

[*English*]

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

Dr. Green, I want to clarify that you are appearing in your capacity as an individual and not on behalf of the B.C. Ministry of Health. Is that correct?

Dr. Stefanie Green: Yes, I am absolutely here tonight as an individual practitioner and not on behalf of any organization.

Mr. Michael Cooper: Thank you very much for that.

You indicated that with respect to the CAMAP curriculum, it was first rolled out on August 31. It's my understanding there are eight different modules. How many professionals have been enrolled in module seven on MAID and mental disorders?

Dr. Stefanie Green: I'm sorry, but who was the question for?

Mr. Michael Cooper: It's for Ms. Campbell.

Ms. Julie Campbell: I don't have that data this evening, but I could provide it.

Mr. Michael Cooper: It's my understanding that it has only very recently been rolled out or that it may not have been rolled out. Is that correct?

Ms. Julie Campbell: It has been rolled out. Module seven for mental disorders has been rolled out and has occurred in numerous locations.

Perhaps Dr. Gubitz has more information on that as well.

Dr. Gordon Gubitz: I'm sorry, but I don't have the specific numbers. However, the modules, as they are in the process of being rolled out, require interested practitioners to apply and register to go through the online pre-learning and then the facilitated module. You are correct that over the coming months there will be increasing numbers involved in the training, but several groups have gone through already.

Mr. Michael Cooper: Thank you for that.

What criterion is set out in the CAMAP curriculum with respect to assessing with certainty that there is irremediability in the case of mental illness?

Dr. Stefanie Green: Again, I'm not sure who it's for, but I'd be happy to answer.

Mr. Michael Cooper: Ms. Green, I was asking about something from the CAMAP curriculum. I would think CAMAP would answer.

Ms. Julie Campbell: I'm sorry, but can you repeat the question?

Mr. Michael Cooper: My time is being eaten by.... Am I losing time because they keep...?

Well, this is ridiculous.

What criterion is set out in the CAMAP curriculum with respect to assessing irremediability in the case of mental illness?

Ms. Julie Campbell: The CAMAP curriculum is quite comprehensive, and each patient is assessed individually using the expertise of people like psychiatrists for those patients, so we would be consulting with them. I'm not a psychiatrist, so if I had that patient, I certainly would be consulting with a psychiatrist around that patient, not just on one condition, but on the patient as a whole.

Mr. Michael Cooper: So, it would be on a case-by-case basis. Is that the guidance?

Ms. Julie Campbell: That's right. Each individual is an individual and has a myriad of conditions, just as we've seen for the past seven years that patients with cancer can have mental disorders.

Mr. Michael Cooper: So there's no listing of criteria saying, here's what you look for to determine irremediability with certainty. That was an issue—predicting it with certainty.

The Joint Chair (Mr. René Arseneault): I think Mr. Gubitz raised his hand.

Dr. Gordon Gubitz: Perhaps I could help, sir.

With respect to the curriculum, the curriculum is a case-based curriculum, and it begins with a series of cases that become increasingly more complex as they go through the discussions. In some of the early cases, the person who was experiencing the mental health issue clearly would not qualify for MAID because they did not meet the criteria, all the way through to more advanced cases in which the clinical course for the patient has been demonstrated to be irremediable—

Mr. Michael Cooper: I'm sorry to interrupt, sir, but I'm asking what the criteria are. What are the criteria?

Further to that, what science is that based on?

Dr. Gordon Gubitz: At the present time, the criteria are based on the ability of the clinician to assess the patient and provide a diagnosis and provide a prognosis based on their past history and how they've been treated. As Dr. Green mentioned in her remarks, a person who has just been diagnosed with a health care problem would not be eligible, and a person who has refused to consider various different treatment options would not be eligible. The sorts of patients who would be eligible would be those who've been treated for many years—

● (2000)

Mr. Michael Cooper: What I'm hearing you say is that there are no criteria, that we're back to where we were a year ago with the expert panel report, and that this is going to be decided simply on a case-by-case basis. I see the model practice standard. There's no guidance there either, so what we have is no guidance.

The Joint Chair (Mr. René Arseneault): Thank you, Mr. Cooper.

[*Translation*]

Over to you, Ms. Koutrakis, for five minutes.

[*English*]

Ms. Annie Koutrakis (Vimy, Lib.): Thank you, Mr. Chair.

I guess this is a good segue after my colleague Michael Cooper's questions.

Any one of our witnesses can answer this. What steps were taken to ascertain the training needs of MAID practitioners, in particular with respect to MAID and MD-SUMC?

That's for any of the witnesses, whoever wants to answer.

Dr. Gordon Gubitz: Sure, I can begin.

When the training curriculum was developed, it was based on other curricula that the Canadian Association of MAiD Assessors and Providers had been doing on an ongoing basis anyway. Each of those experiences resulted in evaluations about the content, about future needs and about things that we would like to do to become better MAID assessors and providers going forward.

A lot of that focused then on providing a detailed basic assessment all the way to more complex things, including complicated track two patients with mental health as the sole underlying condition, recognizing that nobody has practised mental health as the sole underlying condition yet, so there will be some learning going forward.

Dr. Stefanie Green: I would add that the curriculum project also did a needs assessment as they were beginning the process of developing content, and that was a large survey across the country of multiple clinicians, both those with and those without experience, seeing what they were looking for and what they were seeking in an educational program. We took that, along with the evaluation that we'd had from the past seven years of CAMAP training experiences, and put it together with the combined subject matter expertise of the committee of people developing the content.

There were quite a number of inputs on the content development.

Ms. Annie Koutrakis: Does Ms. Campbell want to chime in?

Ms. Julie Campbell: Yes. That module was also piloted, so we took the feedback that came from each module to determine whether it met the needs assessment as well.

The project came from that broad space based on other curricula and what we need, and then moved forward into development with a whole series of experts and stakeholders and reviews. Then it was piloted to a group of people, and that information was reviewed, as well.

Ms. Annie Koutrakis: Ms. Campbell, when you say “experts and stakeholders”, would you be able to clarify for us whether that included indigenous communities, persons with disabilities, persons with mental disorders or any other potential vulnerable groups?

Ms. Julie Campbell: It did. I don't have a list in front of me, but we certainly can submit a list, if you're interested.

Ms. Annie Koutrakis: That would be great.

How long did it take to ascertain what the training needs would be? Was this over two months? Was it over a year?

Dr. Gubitz, go ahead.

Dr. Gordon Gubitz: As mentioned, the training needs were an ongoing assessment from the very beginning of CAMAP's origins in terms of how it was training individuals. The survey that we did across the country took the better part of three or four months. It was completed in English and in French in various jurisdictions and then had to be compiled. From that came the seven modules, with the eighth additional module looking at the resilience of practitioners, which is woven through the other modules.

Ms. Annie Koutrakis: Dr. Green, are you aware of any significant differences between the model practice standard for MAID and standards that have already been established or are being developed across Canada?

Dr. Stefanie Green: I would say that before the model practice standards were produced, there was a lot of discussion and guidance regionally to help understand how the legislation itself might be applied in a clinical situation. As Dr. Downie mentioned earlier tonight, there's legislation that's in law and then there's clinical practice, so we have to find some understanding of whether certain situation criteria have been met under the law, and that's a clinical decision.

I would say that the model practice standard for MAID has been a significant help for those of us who were doing this work in fleshing out some of the nuances about some of the wording that's in the legislation. One of the examples might be “irremediable”, which Mr. Cooper mentioned earlier, or “incurable” and what exactly that means and what goes into satisfying that criterion. That kind of nuanced fleshing out of the meaning has been extremely helpful to clinicians, and that's why I expect that most regulatory bodies have decided to adopt those standards. Those are also being taught in the curriculum.

● (2005)

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Green and Ms. Koutrakis.

Your five minutes is already up.

Please go ahead, Mr. Thériault. You have five minutes.

Mr. Luc Thériault: Our five minutes goes by very quickly, so I will try to say as few words as possible.

Please educate me. Explain the situation to me.

Dr. Green, you talked about who would not be eligible. What would the typical patient look like?

[*English*]

Dr. Stefanie Green: It's a good question. We haven't seen these patients yet, so I can only hypothesize for you.

I think the typical patient who will meet these rarest of criteria would have to be someone with a very long, documented history of interacting with the health care system. They've had numerous treatment trials and have documented which ones worked, which ones haven't worked and how long they've had each treatment trial. They've likely had a number of hospitalizations. They've likely seen a number of specialists over the years. It would require all of that. It's not just about having that lived experience. It has to be documented in the system before I, as a clinician, could come up with what's called a medical opinion about whether they meet the criterion of incurability or irremediability.

Very unfortunately, there will be patients with that lived experience who either didn't have it documented or weren't seen adequately through the years by our medical system, for a number of different reasons. Without that robust history being documented, they likely will not be found eligible for this care.

[*Translation*]

Mr. Luc Thériault: I see. That is still a bit general and vague, but that may be the best we can do right now.

This is for all three witnesses.

As a psychiatrist, you have to determine whether a patient is a danger to themselves on a fairly regular basis. Is that correct?

Can someone give me a yes or no answer?

No one is answering.

The Joint Chair (Mr. René Arseneault): Your mike is on mute, Ms. Green.

[*English*]

Dr. Stefanie Green: I'm sorry.

I'm not a psychiatrist, but it is every clinician's duty to assess each patient for suicidality. We have been doing that, not just in the context of MAID but also in our clinical practice for most of our careers.

That is correct.

[*Translation*]

Mr. Luc Thériault: The resistance to change on the ground is what worries me.

How can a psychiatrist determine the difference between a patient who is a danger to themselves and one who wants to receive MAID?

[*English*]

Dr. Stefanie Green: I think most of us have had experience, over the years, in assessing this difference. It can be complicated.

For a very simple example, I might say that somebody who has a plan to harm themselves has a timeline in which they would do it, has a means of doing so and is expressing it. It's having a kind of intuitive reaction to a negative factor in their life. They might be seen as someone who is acutely suicidal.

Somebody else requesting MAID might come in and tell you they've been talking about this with their family for months or years, and explain what their disease trajectory has been, what their values are, why they believe there's no longer any meaning in their life or why they might want to choose to end their life. They would be willing to work with the team and the clinicians to see whether that's a possibility for them, or whether there are other resources available.

There's a distinct difference between the two.

[*Translation*]

Mr. Luc Thériault: I have a question about the training you're putting together on mental disorders. Did you take into account recommendation 16 of the "Final Report of the Expert Panel on MAID and Mental Illness", which pertains to prospective oversight?

[*English*]

Dr. Stefanie Green: In the curriculum program, we recommend following the practice standards of the local jurisdiction in which you are practising. If the local jurisdiction—say, Nova Scotia, as Dr. Gubitz talked about—requires that a psychiatrist be one of the assessors or part of the team, we would encourage our learners to do so in Nova Scotia. That may or may not be the case elsewhere. It's the same with whether there's prospective oversight or not.

● (2010)

[*Translation*]

Mr. Luc Thériault: The preparatory work on the ground, especially in Quebec, concerns me.

The Quebec government decided not to proceed with this measure, so what impact will this have on patients in Quebec?

[*English*]

The Joint Chair (Mr. René Arseneault): You have 20 seconds.

Dr. Stefanie Green: That will be up to the CMQ, which, up until now—it's my understanding—has said that if clinicians follow one of the laws, provincial or federal, in good faith, they will not be disciplined.

I don't believe the CMQ has commented specifically about this particular situation. Certainly, publicly, they've stated they are against an exclusion. We'll have to see what they say after March 2024.

In the meantime, clinicians are preparing for the possibility.

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Green and Mr. Thériault.

We now go to Mr. MacAlistair for five minutes.

[*English*]

Mr. Alistair MacGregor: Thank you, Chair. It's Mr. MacGregor.

It's okay. If I ever write a book, I'll go by the pseudonym Gregor MacAlistair.

The Joint Chair (Mr. René Arseneault): I'm sorry. I'll start the time.

Mr. Alistair MacGregor: Thank you.

Thank you to all of our witnesses for joining us and helping our committee go through this topic.

Dr. Green, I'd like to start with you. I appreciate the opening comments that you provided to the committee.

I am curious about the development of the curriculum. We now have the latest module, entitled “MAiD & Mental Disorders”. Are you able to inform the committee, when that module was being developed in the early days, when you became aware that Bill C-7 had passed Parliament and this was something you had to start preparing for....? Initially, in the development of that module, are you able to inform the committee what some of the initial feedback or concerns were that you were getting from people whose expertise is in this area?

What were some of the dominant themes they were bringing back that really helped to inform the development of this particular module?

Dr. Stefanie Green: The curriculum was put together by a group of experts who developed this content, as with all the other topics in the curriculum. We asked them for guidance on how we should move forward, and allowed them a certain leeway. They certainly looked to other jurisdictions around the world where this was already legalized to see what they could learn from those jurisdictions about what was working and what was not working.

They also collected a number of experts from across the country, mostly coming with specialty knowledge and expertise in the conditions that were primarily seen in other jurisdictions where this was legal. For example, perhaps they were those with a specialty in mood disorders or substance abuse disorders. They gathered a diverse group of subject matter experts from within Canada who have that generalized expertise based on what they were seeing in other jurisdictions that might be relevant to our experience.

Then together—I was not on that committee—they worked to develop the content, which was reviewed by over 100 different reviewers in this country. There was a multitude of stakeholders from across the country. I believe there were 18 different national stakeholders that reviewed our content before it went to the board for final approval.

Mr. Alistair MacGregor: Thank you.

Ms. Campbell and Dr. Gubitz, do you have anything to add from your own personal experiences on this journey?

I see Dr. Gubitz. Please go ahead.

Dr. Gordon Gubitz: Sure. Thank you for the question.

There were some resounding themes as the module was being developed. They decided, as I mentioned before, to go very case-based, because that's where the meat of the matter is. They facilitated discussions so that the people who were teaching were actually subject experts in the area who could lead people through a very nuanced conversation that deals with capacity, voluntariness, irremediableness, the structural vulnerabilities that Dr. Downie mentioned in the last session, and then the concept that Dr. Green was talking about of whether the patient is suicidal or actually has a reason to wish to die, which is not the same thing.

All of those areas where clinicians struggle are basically the meat and potatoes, if you will, of the different cases in the training module, going from fairly simple to more and more complex. This is recognizing that there are probably more complex cases still, and the modules will be reviewed, evaluated and upgraded over time to reflect current practice and may include other examples going forward.

Mr. Alistair MacGregor: Thank you for that.

Ms. Campbell, do you have anything to add?

● (2015)

Ms. Julie Campbell: What we can add to that is that the curriculum is a really important piece of this, but so are other forums. That richness that Dr. Gubitz was explaining in a case-based review of patients also happens in other areas in which we've gathered to become more ready: in the workshops, in an online forum and in a knowledge exchange. They all come together when we look at patents as individuals, because there isn't a list. When the law was originally written, they didn't write a list of conditions that were eligible. They listed criteria, because people don't fit into boxes very well. They are very complex, so this review of individuals and cases, gathering information from everyone in the room, facilitated by an expert, really brings out a lot of that discussion.

The Joint Chair (Mr. René Arseneault): There are 10 seconds left, Mr. MacGregor.

Mr. Alistair MacGregor: That's okay. I'll cede it to the committee.

The Joint Chair (Mr. René Arseneault): Thanks.

The next questions will be asked by senators.

[*Translation*]

First up is Senator Mégie for three minutes.

Hon. Marie-Françoise Mégie: I thought I heard someone ask about how long the needs assessment is. Having experience in professional development, I'd like to ask Dr. Green or Ms. Campbell a question.

How will the length of the needs assessment affect the training modules you're putting together? Is there a difference between ongoing professional development and MAID training with respect to the needs assessment?

[*English*]

Ms. Julie Campbell: If you're asking whether the module training and the hours put into that are different from ongoing professional development, I would say they're complementary. The modules provide, certainly, a basis of learning that supports that standardization, but we continue to learn. What we knew in 2016 isn't what we know today, and ongoing professional development only adds to the basis of the curriculum.

[*Translation*]

Hon. Marie-Françoise Mégie: Do you have anything to add, Dr. Green?

[*English*]

Dr. Stefanie Green: I'm not sure I understand the basis of your question. I would think that the curriculum project is in fact ongoing professional development. If you're talking about the medical schools and the nursing schools, we're hoping to be in that space as well, but I don't think that's what you're asking—

[*Translation*]

Hon. Marie-Françoise Mégie: Sorry to cut you off, but I just heard some questions around the table.

Does the length of the needs assessment affect how you design the modules? I wouldn't think so, because a needs assessment is time limited. Nevertheless, is there a difference between a needs assessment as part of ongoing professional development and a MAID needs assessment?

[*English*]

Dr. Stefanie Green: I'm sorry. I still don't understand the question.

The needs assessment I referred to before was in order to develop the content of the project. That was an ongoing, months-long process that was done in combination with the gathering of evaluations from other training sessions that happened in the previous seven years. There was an abundance of information from previous training, ongoing training and the needs assessment itself, which was a separate assessment specifically for this particular curriculum development, and that was all put together to help inform the subject matter experts as they developed and implemented the content for this curriculum. I think it's all a crescendo coming together.

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Green.

Dr. Ravalia, go ahead.

Hon. Mohamed-Iqbal Ravalia: Thank you, Chair.

My question is for Professor Gubitz.

Professor, could you clarify for me the process and the potential timelines that an individual with a treatment-resistant or incurable mental illness would have to follow prior to being considered for—

Dr. Stefanie Green: We've lost audio. There's no sound.

The Joint Chair (Mr. René Arseneault): Okay. I'll stop the time.

Can you hear us now?

[*Translation*]

Is the sound better now?

[*English*]

Dr. Stefanie Green: There you are.

● (2020)

Hon. Mohamed-Iqbal Ravalia: Thank you very much.

This is a question for Professor Gubitz.

Professor, could you clarify for me the process and potential timelines that an individual with a treatment-resistant or incurable mental illness would have to follow prior to being considered for MD-SUMC? I'm asking this for clarity, given the rather angry, condescending, demeaning and sometime ludicrous non-scientific inaccuracies regarding access to MAID for MD-SUMC that have been bandied around.

Thank you.

Dr. Gordon Gubitz: The essence of the answer is that the patient who is asking for medically assisted death would have to be able to provide a very detailed history, or a detailed history must be able to be provided about them. That would often come from multiple sources. For patients with psychiatric and mental health disorders, often this is through collateral investigations through psychologists, through a detailed review of patient records, through collaboration with previous family physicians, counsellors, family members, etc. in order for a psychiatrist to come up with an overall diagnostic impression and to be able to assess whether or not all of the avenues have been explored reasonably to ensure that this patient has been using or has attempted to use all of the appropriate treatments for them.

As Dr. Green mentioned, it's not a snap decision. These are track two patients, and it's going to take months to evaluate many of these people to try to figure out if they're eligible.

Hon. Mohamed-Iqbal Ravalia: Dr. Green, could you follow up, then, and tell me, based on your clinical experience, the numbers that would qualify in this situation? Would you be able to perhaps just hazard a guess? Are we talking tens or hundreds?

Dr. Stefanie Green: We're talking small numbers, less than hundreds, for sure, in the teens. In the number of patients I've seen over the seven years—there have been hundreds of patients I've seen—very few have come forward due to mental illness up until this point. I cannot imagine that there will be very many out there who will be able to meet all of the rigorous standards. The eligibility criteria are rigorous. The safeguards are robust. It will be quite difficult for those with mental health disorders. I would say that probably for every hundred who apply, I would imagine one or two might be eligible.

Hon. Mohamed-Iqbal Ravalia: Thank you for your clarity on those safeguards; it's much appreciated.

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Ravalia.

Madame Wallin, you have the floor.

Hon. Pamela Wallin: Thank you very much.

I want to follow up on the same theme as Senator Ravalia, which is the concern that's often raised about whether there will be too much access to MAID for those with mental illness.

It seems to me—given what you've said, Dr. Green, and what you've said, Dr. Gubitz—that the issue is really on the other side. The concern is about access to it. You both highlighted the fact that it's going to be very difficult and that you're going to have to have documentation that people with mental illness might not be able to provide. You're going to have to see earlier documents from people who have treated them in another way, whether or not they have the capacity to put that all together.

We'll go to Dr. Green first. What is your most serious concern coming at it from that perspective?

Dr. Stefanie Green: I have the privilege of sitting with people when they come to me in a desperate situation asking me to help them end their life, which is a very intimate time. When someone comes to do that, they are often desperate, and there are times when I have to tell people that they are ineligible.

The greatest risk here is that people—and I'm not a legal scholar—cannot be told that they're not eligible for legalized medial care in this country based on a diagnosis. That seems blatantly discriminatory. The biggest risk here is people feeling they've been excluded from accessing care that others are able to access. The risk then will become what they will do in that situation.

● (2025)

Hon. Pamela Wallin: Dr. Gubitz, that's what we've been hearing in testimony, that if you're going to make the constitutional argument that they have the same right as others to seek MAID, we put a lot of barriers into this particular category.

Dr. Gordon Gubitz: I would agree. For us and the group we're working with in Nova Scotia, the question becomes this: What happens to people who apply for a medically assisted death but who are not eligible? Who cares for them then? Our MAID access team in Nova Scotia is not a treatment team for people with mental health disorders. Sometimes these people lack some of those basic circumstances. They don't have a family physician or nurse practitioner to care for them even for their primary needs. For us, it's then a discussion with our government as to how we care for these people if they're not eligible.

Hon. Pamela Wallin: We heard that before, that we need two tracks, in the sense that there have to be money and system readiness on this side, but there also have to be money, services and system readiness for those who cannot access MAID but who still struggle with mental illness.

Dr. Gubitz, go ahead.

The Joint Chair (Mr. René Arseneault): I'm sorry, Ms. Wallin.

I'm sorry, Dr. Gubitz. That's all the time we have.

Madame Martin, the floor is yours for three minutes.

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

I want to go back to Ms. Campbell.

I didn't hear the answer specifically to my colleague about the criteria set out in the CAMAP curriculum with respect to assessing irremediability in the case of mental illness with certainty. I know you talked about the cases that are discussed. It's on a case-by-case basis, but there must certainly be criteria discussed, a list of things you're instructing the MAID assessors on.

Ms. Julie Campbell: I think there's a wish for a simple checklist that doesn't exist, because people are complicated.

Let's take an individual and follow what Dr. Gubitz just outlined for you. We're talking to their psychiatrist and psychologist, reviewing their conditions, and asking what treatments they've tried, what treatments worked, what treatments didn't work and what the results of those were. It's the answers to all those questions that start to build a picture around irremediability.

It's not as simple as, “Do they have this condition? Is it irremediable?” It is an in-depth, thorough review of that patient and all the people involved in their history and what that looks like.

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

Well, it's not a wish. Rather, we're trying to ascertain the quality of training. We're talking about people's lives. Whether it's in the tens or hundreds, we're talking about individual lives.

Perhaps for assurance, would you be able to provide the committee access to this module? I know, as a former educator, that seeing it in print would definitely give us some assurance. Is that something you can provide to the committee, Ms. Campbell?

Ms. Julie Campbell: I don't know the answer.

The Joint Chair (Hon. Yonah Martin): Can CAMAP provide the module being used, in order to assure us? It's just for us. We are not experts. At the same time, seeing it in writing will give us that sort of assurance. I believe the training is being undertaken, and I know everyone is learning the practice, but it is important for us to see that module.

Is that something you could provide?

Ms. Julie Campbell: It's a question I could certainly ask the board, but it's not a decision I would like to make independently at the moment, unless Dr. Gubitz or Dr. Green has more information.

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

Dr. Gubitz, just quickly, you mentioned in your remarks that there's an addictions specialist who was recently hired. Is that correct?

Dr. Gordon Gubitz: We had an addictions specialist as part of our provincial advisory group developing the documentation, yes.

The Joint Chair (Hon. Yonah Martin): Does that mean you're also anticipating that, potentially, people with addictions would be eligible?

● (2030)

Dr. Gordon Gubitz: It's entirely possible, yes. As long as they meet all the criteria, it's possible.

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you, Mr. Gubitz and Ms. Martin.

Now we will go to MPs for questions.

Mrs. Kramp-Neuman, you may go ahead for three minutes.

[*English*]

Mrs. Shelby Kramp-Neuman (Hastings—Lennox and Addington, CPC): I have some concerns.

Have there been actual, real-life conversations with individuals with lived experience with mental illness? Have they been adequately consulted with respect to the potential implementation of enticed suicide to escape a very painful death?

Ms. Green, would you like to answer that?

Dr. Stefanie Green: It's Dr. Green.

Yes, I can tell you that we have been fortunate enough to involve people with lived experience on several of the content committees for the development of the MAID curriculum project—in particular, for module seven on MAID and mental illness. This is not only about MD-SUMC but also about when mental illness is a comorbidity. There was a person with lived experience on the committee developing the content, so there has certainly been an effort to do that, from the CAMAP curriculum point of view.

Does that answer your question?

Mrs. Shelby Kramp-Neuman: I can move on from there.

To my knowledge, and from what we've gathered earlier, there is no real, solid data about socio-economic factors driving requests for MAID for individuals with mental illness. If we're providing marginalized, lonely, homeless and potentially suicidal people a premature death based on unscientific medical assessments, I'm concerned about where we are at as a country. Is Canada ready for this?

Dr. Stefanie Green: There's no evidence that people with those characteristics are actually requesting and receiving MAID in a higher proportion in Canada. We actually have evidence to the contrary.

The increased data that's being collected right now by Health Canada, since January 2023, will be reported in 2024, and it will give us a more fulsome picture of the people who are requesting and receiving MAID. I think that would be helpful.

As with other jurisdictions around the world, we absolutely do not see those drivers for MAID and we don't expect them to be in Canada. We know very clearly, from the very clear eligibility criteria, that socio-economic vulnerabilities on their own do not allow someone to become eligible for MAID.

Obviously, as Ms. Campbell mentioned, people are quite complicated and it's hard sometimes to discern which factors are involved. It's not to say that people with those factors do not come forward and ask for MAID, but there's a difference between that and a screaming headline that says someone with a vulnerability is trying to access MAID. There's a difference between being assessed for MAID and being found eligible for MAID. It's important that this committee keep that in mind.

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Green.

[*Translation*]

Thank you, Mrs. Kramp-Neuman.

[*English*]

We have Mr. Scarpaleggia for three minutes.

Mr. Francis Scarpaleggia: Thank you very much.

I have a couple of quick questions.

I forget who said it, but I think maybe it was Dr. Green who said that to be eligible for MAID in cases of mental illness, a person would basically not have been allowed to refuse treatment in the past. Is that correct? Did somebody say that? Did I understand correctly?

Dr. Stefanie Green: What I said was that if somebody had been offered treatments and refused them and gave no particular rationale as to why, they couldn't just come forward and say, “Well, I refused those treatments and therefore I'm still eligible.” That is certainly not the case, and they would not be found eligible.

Mr. Francis Scarpaleggia: They'd have to have a reason. I'm sure there are many. For example, a person may have tried many treatments but then balked at one particular treatment. For whatever reason, they didn't want to have electroshock therapy. Maybe that might not be considered a sufficient reason, but they wouldn't be disqualified because they refused one of many treatments. The evaluation is a little more subtle than that, I would imagine.

Dr. Stefanie Green: The evaluation is much more subtle than that, and we would look to see if maybe they'd tried a similar medication and found the side effects unacceptable to them. Every case is different. It's case by case.

Mr. Francis Scarpaleggia: What I heard was that when it comes to irremediability, it's very complex. You have to look at the whole situation, and there's no test for irremediability.

I would like your opinion on an abstract from an article published by Cambridge University Press called “Irremediability in psychiatric euthanasia: examining the objective standard”. I'll read you the abstract and maybe you can comment on it.

> Irremediability is a key requirement for euthanasia and assisted suicide for psychiatric disorders (psychiatric EAS). Countries like the Netherlands and Belgium ask clinicians to assess irremediability in light of the patient's diagnosis and prognosis and "according to current medical understanding". Clarifying the relevance of a default objective standard for irremediability when applied to psychiatric EAS is crucial for solid policymaking. Yet so far, a thorough examination of this standard is lacking.

This was published only a year ago. I would elicit a comment, one way or the other, on this particular article.

Dr. Green, go ahead.

● (2035)

[*Translation*]

The Joint Chair (Mr. René Arseneault): Your mike is on mute, Dr. Green.

[*English*]

Dr. Stefanie Green: I'm very sorry.

This question has come up repeatedly. I think what I would do is encourage the members of this committee to review the model practice standards for MAID, where these notions of what "irremediable" means are fleshed out. I can't find it in front of me right now, but there is a paragraph that explains what goes into something being incurable or something being irremediable or something being irreversible. By no means are they the be-all and end-all, but they give a sense of what is involved in this.

I do have the paragraph in front of me if you have time to hear it.

[*Translation*]

The Joint Chair (Mr. René Arseneault): You have two minutes, Mr. Thériault. Go ahead.

Mr. Luc Thériault: In a nutshell, what the three of you said is that only a small number of people would be eligible given the parameters you had developed. The person must have tried everything and cannot have refused treatment that would without question improve their condition, even though a person is still allowed to refuse treatment.

If, indeed, a small number of people will have access to MAID, in light of all the parameters you're putting in place, can it be argued that making MAID available to people with mental disorders could have a preventive effect?

Dr. Gubitz can answer that, since I haven't asked him a question yet.

[*English*]

Dr. Gordon Gubitz: I think we know that for MAID in general, the involvement of a MAID assessment will often improve the health care of the person. For example, if they have not accessed palliative care services, and they do, they find some benefit so that they don't have to have a medically assisted death and can die comfortably under the care of palliative care. That's an example generally speaking.

I think that if we are being truthful about how we assess people with mental health disorders, we sometimes need to push the standard a bit, go into the depths and ask, "What have you tried? What have you not tried? Oh, I found this. It's something you might be interested in thinking about, and it's something we could trial to see if it makes sense for you." That's the reason we have to have people who have expertise in the subject area.

As Dr. Downie mentioned, it doesn't necessarily need to be a psychiatrist, because many primary care physicians who have been looking after certain populations of patients are experts in their treatment. It's really about knowing the condition, knowing the patient and getting a sense of "Have I really done my due diligence in caring for this person?"

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Gubitz.

For the interpreters, please, as much as we can, we should speak very slowly. I'm used to being told that.

Mr. MacGregor, the floor is yours for two minutes.

Mr. Alistair MacGregor: Thank you very much, Mr. Chair.

Dr. Green, I guess I will finish this round with you.

If it had not been for Bill C-39, which Parliament passed really quickly, we would, of course, be living in a country right now where mental disorders as a sole underlying medical condition would be eligible for MAID.

Looking at it from British Columbia's perspective, how did that additional year factor into the degree of preparation in our province? According to you, given how involved you are in this, when was the determination made that our province was ready, approximately? I'm just trying to walk backwards in the timeline here.

● (2040)

Dr. Stefanie Green: British Columbia has always had some foresight in seeing things come down the pipe. For example, British Columbia developed a provincial working group that's been preparing for MD-SUMC since September 2022. It certainly took the extra time; it's been over a year now. That is a subcommittee of a different committee of the Ministry of Health, which took the expert panel recommendations and took the model practice standards into account and has now proposed new provincial safeguards with the creation of a case review committee for all MD-SUMC cases, for example.

Three of the regional health authorities are already ready to establish this case review committee. One of them is already running something very similar to that, and certainly all of them will be ready by March 2024. Both our regulatory authorities, the medical and nursing colleges, are making changes to the medical practice standards for the province based on the model practice standards and the working group's recommendations.

I think with all of that work having been done in the past year, the province feels ready to move forward. When did they say they were ready? I would say they're saying it now as they realize things are falling into place on time. Did we take advantage of the extra year? Absolutely, we did.

The Joint Chair (Mr. René Arseneault): Thank you, Mr. MacGregor.

[*Translation*]

Thank you, Dr. Green.

[*English*]

Hon. Pamela Wallin: I have a point of order.

I'm just not sure we should be requesting access to the professional training for a professional body. I don't know whether that's appropriate. I know they were going to go back to the board and ask about it, but I think that's kind of a questionable request. That's all.

Mr. Michael Cooper: Madam Chair, let me just say that I guess for CAMAP, it's one big secret. Then again, this is an organization that had training programs in which they were discussing, among other things, sedating patients who were resisting the administration of MAID. That's what we're dealing with, with CAMAP.

Hon. Pamela Wallin: It was just a point that I wanted to put on the record. That's it. I don't think it requires debate.

The Joint Chair (Mr. René Arseneault): Okay. Thank you.

I'd like to thank all the witnesses.

We will suspend momentarily to welcome the next panel of witnesses for the third hour.

● (2040)

_____(Pause)_____

● (2045)

The Joint Chair (Hon. Yonah Martin): I call the meeting back to order.

Colleagues, we will resume at this time.

I'd like to welcome our main witness, but there are two. We have a second person there in case additional backup is needed.

We welcome Dr. Jitender Sareen, a physician with the department of psychiatry at the University of Manitoba, by video conference. He is accompanied by Dr. Pierre Gagnon, director of the department of psychiatry and neuroscience at Université Laval. Welcome to you both.

Dr. Sareen, you will have five minutes for your opening remarks, and then we'll go right into the first round of questions. We have one witness presenting testimony to start.

Dr. Sareen, the floor is yours for five minutes.

Dr. Jitender Sareen (Physician, Department of Psychiatry, University of Manitoba): Thank you so much, Chair.

Thank you for the opportunity to speak to the Special Joint Committee on Medical Assistance in Dying.

I would like to acknowledge that the University of Manitoba campuses are located on the original lands of the Anishinabe, Cree, Oji-Cree, Dakota and Dene peoples, and on the homeland of the Métis nation. We respect the treaties that were made on these territories, acknowledge the harms and mistakes of the past and dedicate ourselves to moving forward in partnership with indigenous communities in a spirit of reconciliation and collaboration.

With regard to this testimony, I have no conscientious objection to MAID. I am an adult psychiatrist with clinical and research experience in suicide prevention for over 20 years, with over 400 peer-reviewed publications, 150 in suicide prevention.

In 2019, I testified on behalf of the Attorney General of Canada in the Truchon case. I co-chaired the federal 2016 expert panel on suicide prevention in the military with Dr. Rakesh Jetly.

Today, I am representing the department of psychiatry at the University of Manitoba and Shared Health in Manitoba. I am here with Dr. Pierre Gagnon, department chair of psychiatry at Université Laval, but we are also representing six other department chairs of psychiatry departments in multiple provinces in the country: Jack Haggarty from the Northern Ontario School of Medicine, Karin Neufeld from McMaster, Gustavo Turecki from McGill, Sarah Noble from Memorial University, Simon Hatcher from the University of Ottawa, and Leslie Flynn from Queen's University. Collectively, we have decades of experience in clinical practice, suicide research and responsibility for education and training of psychiatrists and medical learners.

We strongly recommend an extended pause on expanding MAID to include mental disorders as the sole underlying medical condition in Canada, because we're simply not ready. In our experience, people recover from long periods—"long" meaning decades—of suffering with depression, anxiety, schizophrenia and addictions with appropriate evidence-based treatments. We strongly believe that making MAID available for mental disorders will facilitate unnecessary deaths in Canada and negatively impact suicide prevention efforts. The clinical role is to instill hope, not to lead patients toward death.

We have carefully reviewed the 2023 Health Canada model standard for MAID. In September 2023, we wrote to the federal ministers expressing the following concerns. The standard does not require the involvement of a psychiatrist in the assessment process for all MAID assessments for mental disorders. There is no international or accepted definition of irremediability in mental disorders and addictions; you can look at past treatments, but the most important question is what is going to happen in the future. There is no accepted operational definition to differentiate suicidal ideation and medical assistance in dying requests among people who are not dying. There are inadequate safeguards to protect vulnerable groups that are disproportionately affected by mental disorders. Due to geographic barriers, patients in underserved areas will be more likely to obtain MAID instead of evidence-based care. International experience has clearly demonstrated that MAID is being used in common and treatable mental disorders and is not reserved for the very rare and refractory conditions. The Health Canada standard does not guide psychiatrists on how many treatment trials are required before recommending MAID, because there's no evidence on this particular issue.

The proponents of MAID believe that it is discriminatory to exclude people with mental disorders from accessing MAID, but we completely disagree with this. Equity does not mean each person gets the same treatment. Unlike physical conditions that drive MAID requests, we do not understand the biological basis of mental disorders and addictions, but we know that they can resolve over time. The real discrimination and lack of equity is not providing care for people with mental disorders and addictions.

Advocates of expanding MAID suggest that only a small fraction of psychiatrists need to be trained to prepare for MAID in 2024. Again, we disagree. Should MAID eligibility expand, all Canadian psychiatrists will need to grapple with how to deal with suicidal ideation in the context of mental illness. They will need to determine when to refer for MAID versus addressing suicidal ideation with medications, treatment and sometimes involuntary hospitalization.

● (2050)

Repeated Canadian surveys demonstrate that most psychiatrists are not in favour of MAID, and the Canadian Mental Health Association and the Canadian Association for Suicide Prevention are against the expansion of MAID to include mental disorders. Finally—

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

Dr. Jitender Sareen: Can I finish?

The Joint Chair (Hon. Yonah Martin): You may finish with a final statement, yes.

Dr. Jitender Sareen: Finally, we've reviewed the Carter and Truchon decisions, and we underscore that mental disorders were not tested in these cases. After careful debate in the Quebec assembly, they decided not to expand MAID to include mental disorders. We strongly believe Canada should follow their lead and not expand MAID to include mental disorders.

Thank you.

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

We'll begin with Mrs. Shelby Kramp-Neuman.

Mrs. Shelby Kramp-Neuman: Thank you.

Thank you, Dr. Sareen, for your testimony this evening.

We've heard assurances that there will be a very small number of patients who qualify for MAID for mental illness. Is that true?

Dr. Jitender Sareen: It's not true at all. We have a lot of people in the community who deal with treatment-resistant depression or treatment-resistant schizophrenia, and the Health Canada standard does not require treatment. It says that you have to have some treatment, but it doesn't require treatment. This is really a major issue, and there's lots of evidence from other countries as well that there will be more requests and completions, because our laws don't prevent people from accessing MAID without going through a number of different treatments.

Mrs. Shelby Kramp-Neuman: Thank you.

We've also heard assurances that people will get MAID for mental illness only if they've had years of unsuccessful treatments, and yet I'm not aware of any actual safeguards that would require that. If MAID is expanded to include mental illness conditions in March 2024, is it true that only people with extensive treatment histories will qualify for MAID, or would Canadians be able to get assisted suicide for mental illness if they have not yet had access to or tried standard treatments?

Dr. Jitender Sareen: That is exactly our concern with the standard. It does not state that the person has to go through treatment. It's encouraged, but it's not necessary.

Again, the idea of someone who has thought reasonably about suicide and MAID is more concerning, as far as risk of suicide goes, than somebody who is in crisis. Some of the testimony before was around whether somebody had planned it very carefully. That's not suicide; that's MAID. As a suicide researcher and a clinician, I'm much more concerned about the person who's thought about suicide for a long time and has planned it than about someone who's in crisis. Both are at risk.

● (2055)

Mrs. Shelby Kramp-Neuman: Thank you for that.

We've also heard reassurances that psychiatrists are trained and know how to separate suicidal ideation due to mental illness from psychiatric MAID requests, and that suicidal people will not get MAID. Do you feel that's true?

Dr. Jitender Sareen: Again, it's false, because there is no clear operational definition differentiating between when someone is asking for MAID and when someone is asking for suicide when they're not dying. Internationally, this is the differentiation. If somebody is dying, then it can be considered MAID. When they're not dying, it is considered suicide. It's very difficult, and there's no operational definition on it.

Mrs. Shelby Kramp-Neuman: Thank you.

Last year, the Association of Chairs of Psychiatry in Canada wrote to the government calling on it to delay MAID for mental illness, citing a pure lack of readiness. Among the issues cited was a lack of certainty around determining irremediability in the case of mental illness, and a lack of understanding with respect to distinguishing a request for MAID from suicidality.

My first question is, are we any better off now than we were a year ago when it comes to reliably determining irremediability?

Dr. Jitender Sareen: No, we're not. We haven't changed from a year ago.

Mrs. Shelby Kramp-Neuman: It's sadly so. Are there any adequate guidelines that you're aware of on how to distinguish a request for MAID from one for suicide? Has that changed from one year to the next?

Dr. Jitender Sareen: No. We have carefully reviewed the standard. Again, to emphasize, we as psychiatrists providing education and training think there is no differentiation, at this point, between MAID and suicide requests.

Mrs. Shelby Kramp-Neuman: Do you feel there's a consensus among psychiatrists to move forward with MAID for mental illness?

Dr. Jitender Sareen: There have been repeated surveys on this issue. We were one of the first to do this survey in 2017. The majority of surveys have shown that the majority of psychiatrists are against MAID for mental illness, because of all the factors we have discussed, such as no evidence of guidelines around irremediability. The idea around irremediability that you heard in the testimony was around how many trials a person has had over the last number of years.

I can tell you a story about a patient I treated—

The Joint Chair (Hon. Yonah Martin): I'm sorry, Dr. Sareen. It's past the five minutes. Thank you very much for that.

Next, we'll go to Mr. Maloney.

Mr. James Maloney (Etobicoke—Lakeshore, Lib.): Thanks, Madam Chair.

Doctor, I'm going to pick up where my colleague left off.

The issue of readiness, from my perspective, is a consideration of whether it's irremediable or not. If you have 10 doctors examining a patient who has terminal lung cancer, they're all going to agree it's not going to get better. However, if you have 10 psychiatrists examining somebody with a mental disorder, you're going to have varying degrees of opinion.

Do you agree with that?

Dr. Jitender Sareen: Absolutely.

Mr. James Maloney: Some of those opinions aren't about severity. Some of them are about whether or not it's curable or can get better. Is that right?

Dr. Jitender Sareen: Exactly.

Mr. James Maloney: That's the nut of it.

Do you believe, Doctor, that there are cases of people suffering from a mental disorder that is irremediable?

Let me rephrase that. The reason I'm asking is that the challenge is in determining which ones those are. I'm not sure we're at a stage now where there are safeguards to identify the cases where you'll get 10 out of 10 doctors saying, "It's irremediable."

That's a fairer way to put it, I think.

Dr. Jitender Sareen: Yes.

Again, I have seen it personally. The story I was going to tell you was about a patient of mine who had stroke-related OCD symptoms in her sixties. I treated her for about two to three years with different types of medication. We tried ECT, and over a five-year period, we were able to get her feeling better. She was able to live 10-15 years afterwards, and she only died related to COVID.

Again, the science is not there. As you said, when you have cancer, a physical biology is driving the death. In mental disorders, there is no biological factor. This is where irremediability is impossible to define.

● (2100)

Mr. James Maloney: I think you've already answered this. You've read the definition of "incurable" in the model practice standard—although we haven't seen the model practice standard. I think you made it clear you don't think the language in this is strong enough.

Dr. Jitender Sareen: Yes, that's correct.

Mr. James Maloney: It's language that might be strong enough to protect a doctor in a legal setting, but it's not strong enough to close off all the problems from a medical perspective. Is that a fair way to put it?

Dr. Jitender Sareen: Exactly.

Mr. James Maloney: Have you looked at or taken the...? I think it's module seven of the practice standard for mental health. Have you completed it yourself?

Dr. Jitender Sareen: I registered to look at it in preparation for this meeting, but I have not reviewed it yet.

Mr. James Maloney: Are you aware of the content of it, generally? Do you know what the curriculum is, if I can put it that way?

Dr. Jitender Sareen: No, I have not seen it. Again, I have not seen the details of it.

Mr. James Maloney: Have you talked to other practitioners or psychiatrists who have completed it, and received their opinion on whether it's adequate or not?

Dr. Jitender Sareen: In my jurisdiction, Manitoba, I'm not aware of any psychiatrists who have completed it.

I have one psychiatrist who is part of the medical assistance in dying team. He went to the June meeting, and he was quite concerned about the lack of safety around MAID for mental disorders. He was quite concerned that cases considered to be slam dunk for getting MAID were quite treatable, especially in older adults.

What I'm hearing is quite a bit of concern around this.

Mr. James Maloney: You mentioned today that you're speaking on behalf of not only your colleague Dr. Gagnon, who is with us today, but also six other physicians from six other institutions. How did your group come together?

In the event that I run out of time when you're answering that question, my final question is, can we ever be ready?

The Joint Chair (Hon. Yonah Martin): You have about 40 seconds.

Dr. Jitender Sareen: We're part of the Association of Chairs of Psychiatry. We're eight chairs out of the 17 medical schools. That's how we came together.

I don't think that right now the evidence is clear enough to guide us to be ready at any time in the near future.

Mr. James Maloney: Thank you, Doctor.

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

Next, we have Monsieur Thériault, for five minutes.

[*Translation*]

Mr. Luc Thériault: Thank you, Madam Chair.

Dr. Sareen, how long have you been a psychiatrist?

[*English*]

Dr. Jitender Sareen: I need translation, or Dr. Gagnon could answer.

[*Translation*]

Mr. Luc Thériault: You have to choose the right channel for interpretation.

Madam Chair, you may have to let the witness know that they need to choose the right channel for interpretation.

[*English*]

The Joint Chair (Hon. Yonah Martin): There is an interpretation channel at the bottom of your screen. You can select English as your option.

Dr. Jitender Sareen: Okay, I got it.

The Joint Chair (Hon. Yonah Martin): Monsieur Thériault, you may begin again.

[*Translation*]

Mr. Luc Thériault: Thank you.

My question was simple. How long have you been a psychiatrist?

[*English*]

Dr. Jitender Sareen: I got my licence in 2000, so 23 years.

[*Translation*]

Mr. Luc Thériault: Very good.

After 23 years in clinical practice, are any of your patients still with you?

● (2105)

[*English*]

Dr. Jitender Sareen: I have had some patients who died of either suicide or other causes of death.

[*Translation*]

Mr. Luc Thériault: I see.

In your view, no mental illness or disorder is incurable or irremediable.

[*English*]

Dr. Jitender Sareen: Mental disorders are not irremediable, in the sense that recovery-oriented practice.... People have disabilities and people have depression, but there is always.... The desire for death waxes and wanes over time.

We work with patients—

[*Translation*]

Mr. Luc Thériault: Sorry to cut you off, but I want to know whether you have treated a patient whose mental disorder was incurable and became chronic.

In your clinical practice, have you never had a patient whose illness was chronic?

[*English*]

Dr. Jitender Sareen: Yes, I've had a chronic patient.

[*Translation*]

Mr. Luc Thériault: All right.

I imagine those patients had varying degrees of suffering. You said that some had committed suicide. Is that correct?

[*English*]

Dr. Jitender Sareen: Yes.

[*Translation*]

Mr. Luc Thériault: Very well.

How do you explain that?

[*English*]

Dr. Jitender Sareen: Are you asking me to explain how some people died by suicide?

[*Translation*]

Mr. Luc Thériault: When you see a patient with a chronic illness for a long period of time and that person decides to commit suicide, do you see that as a failure of your treatment, or do you think there was nothing you could have done?

From that standpoint, don't you think that when certain individuals reach the point that your patient was at—and I imagine you're an excellent psychiatrist—they would have opted for MAID over suicide, if they could?

If so, in light of your experience, would it not have been preferable for those people to have access to MAID, rather than being driven to suicide after years of receiving treatment from you?

It's a simple question.

[*English*]

Dr. Jitender Sareen: Sir, every single day we admit patients to the hospital with exactly what you're describing. What you're pointing out, sir, is exactly what our psychiatric practice does. Every single day we admit people who've had years of suffering, who then have thoughts about dying and reach out to their psychiatrist.

[*Translation*]

Mr. Luc Thériault: I have one last question for you, Dr. Sareen.

In certain cases, don't you think that all psychiatry can do for patients suffering from chronic mental disorders is provide palliative care indefinitely?

[*English*]

Dr. Jitender Sareen: I think what you're saying is that MAID and suicide are the same thing. Isn't that correct?

That's exactly why we're saying that every psychiatrist in the country will need to understand, when somebody shows up with suicidal ideation, whether we should be sending them for a physician-assisted death or admitting them to the hospital.

[*Translation*]

Mr. Luc Thériault: A suicidal state is, however, reversible. Is it not?

[*English*]

Dr. Jitender Sareen: I don't understand your question, sir.

[*Translation*]

Mr. Luc Thériault: A suicidal state is reversible and can be treated. A patient whose state is reversible should therefore not have access to MAID. Only when a person's state is irreversible can they not be treated.

I would think that after years of care, therapy and best practices, professionals would have developed that certainty.

[*English*]

The Joint Chair (Hon. Yonah Martin): Unfortunately, the time has expired.

We will go to Mr. MacGregor for the next five minutes.

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

Dr. Sareen, we're in a situation where we're not relitigating the change in the law. That's happened, and Parliament recently gave its voice to that. We have a very narrow focus.

In your opening comments, I think I heard you say that you recommend "an extended pause" on the law coming into effect. Can you elaborate on that a bit more? What do you mean by "an extended pause"?

● (2110)

Dr. Jitender Sareen: It means that we're not going to be ready in another year. Some of these issues are very complicated, and we do not believe that if there's a delay by one year these issues are going to be resolved—around irremediability and around differentiating suicide from MAID. That's why we're asking for an extended pause.

That's what the Quebec government has done. They've looked at this issue very carefully and seen that there is no evidence of guidelines to say that this person has gone through multiple years of treatment and is not going to recover.

Mr. Alistair MacGregor: Thank you.

For practical purposes, this committee has to table a report by January 31. Is that extended pause two or three years? Do you have a number that you think this committee should recommend?

Dr. Jitender Sareen: We would recommend an indefinite pause.

Mr. Alistair MacGregor: Okay.

Dr. Jitender Sareen: Again, people with mental disorders in track two are still having access, but it's really around the physical health issues.

Our group feels that it's an indefinite pause.

Mr. Alistair MacGregor: I'm borrowing from your expertise with the patients you deal with. Say someone is coming in and seeking MAID for a mental disorder as a sole underlying medical condition; because their death is not reasonably foreseeable, they're going to come under the track two process.

There's a requirement, of course, to have two professionals look at it. If one practitioner is having difficulty determining whether this is a legitimate request for MAID or a manifestation of suicidal ideation, does the requirement for another professional stepping in not give you a little bit of comfort due to the fact that two professionals are required to arrive at the same conclusion?

Dr. Jitender Sareen: It goes back to the idea that there's no clinical practice and no guidelines to differentiate this.

I am not only the department head, but I'm also the Shared Health lead. We worked in Manitoba with our MAID team and our college to try to come up with criteria. The college and the MAID team said to ask a psychiatrist about when they would say it's time to give MAID instead of giving people treatment. There's no evidence to guide us on that.

You can have two opinions, but if it's not seated in evidence, then people are just deciding to provide MAID instead of treatment.

Mr. Alistair MacGregor: All right. Thank you very much.

I will leave my questions there.

[*Translation*]

The Joint Chair (Mr. René Arseneault): Thank you, Mr. MacGregor.

Thank you, Dr. Sareen.

We will now go to senators for questions.

Dr. Mégie, you may go ahead for three minutes.

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

Dr. Sareen, I have just a quick question for you.

In your opening statement, you said that if MAID were made available, it would lead to many unnecessary deaths.

Is the availability of MAID and eligibility for MAID the same thing, in your eyes?

[*English*]

Dr. Jitender Sareen: No, that's not how I perceive it. The important thing to note is around suicide contagion. When a society makes MAID available, the population believes it is a way to end suffering. In other jurisdictions that have had MAID available for mental disorders, not only are there deaths due to MAID, but there are also deaths related to non-MAID suicides.

I just want to emphasize that it's not a suicide prevention mechanism. It's really a way.... We're actually going to make not only suicide deaths go up, but also MAID deaths go up.

I really want to emphasize that people have lots of untreated mental illnesses and addictions in our society, and we should be spending a lot more energy on trying to make sure that people are getting evidence-based care, rather than focusing as much on MAID. There have clearly been reports about people in British Columbia showing up to the emergency department and somebody saying, "Have you thought about MAID?" We've had veterans who have been asked if they would rather have MAID, instead of a wheelchair.

We really have to be thoughtful about the unintended consequences here of making MAID available for mental disorders in Canada, and these safeguards are false reassurances.

Really, we don't agree with proceeding at this point.

● (2115)

[*Translation*]

Hon. Marie-Françoise Mégie: Do I have any time left?

The Joint Chair (Mr. René Arseneault): You have 30 seconds.

Hon. Marie-Françoise Mégie: If I understand correctly, you do trust your colleagues to assess the risk of suicide. It already says in black and white that someone in a state of suicidal crisis is not eligible for MAID. It says that clearly, and it's stated over and over again.

What do you think of people who provide MAID to a person in crisis? Is there a way to stop that from happening? It is not good medicine and it is not MAID.

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Mégie.

You have 10 seconds to answer, Mr. Sareen.

[*English*]

Dr. Jitender Sareen: Again, I would emphasize that I don't have any objections to MAID itself for physical illness or when people are dying. We're talking about MAID for mental disorders as a sole underlying condition, and there is no evidence to differentiate a MAID request from a suicide request. Whether it's planned—

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Sareen.

Senator Wallin, the floor is yours for three minutes.

Hon. Pamela Wallin: I just have a comment as we begin here. You've repeatedly said there is no evidence yet on access to MAID for mental illness. I want to state, for the record, that of course there isn't. It's not the law yet, so it's hard to collect the data and the information on a practice that doesn't exist.

I have two questions for you. I'll pose them both, and then you can answer them.

Whom exactly do you represent? Have you actually consulted with all of the psychiatrists in your departments, hospitals or universities, or as chairs? Have you done this?

Second, can you give us either a legal or a medical, clinical definition of “suicide contagion”? Is that a medical fact? Is that a legal construct? What does that mean?

Dr. Jitender Sareen: I consulted my department of psychiatry last year. We did a survey. I represent the department of psychiatry at the University of Manitoba and Shared Health. My colleagues are department chairs, and they're represented individually. They are in the position of trying to take this information and implement education and training.

Hon. Pamela Wallin: How many people do you speak for, exactly?

Dr. Jitender Sareen: I speak for 150 psychiatrists in Manitoba.

Hon. Pamela Wallin: Do all of them agree with your position?

Dr. Jitender Sareen: The majority of them do, yes.

Hon. Pamela Wallin: What would be the number?

Dr. Jitender Sareen: It's probably close to 120.

Hon. Pamela Wallin: How many psychiatrists are in Manitoba?

Dr. Jitender Sareen: There are about 150. There are more than that, actually. I'm just talking about my department.

● (2120)

Hon. Pamela Wallin: That's what I thought.

Maybe you could answer the other question, then, about whether suicide contagion is a recognized legal or clinical condition.

Dr. Jitender Sareen: The contagion effects around suicide.... When there's a celebrity who dies by suicide.... There's clearly been lots of evidence around it. I was part of co-authoring the Canadian Psychiatric Association's media guidelines around suicide contagion in 2008. It's been worldwide.

As far as suicide prevention—

Hon. Pamela Wallin: No, no. Does it have a legal status or a clinical status?

Of course, we can read in the newspaper online that there are copycats, but that's different.

Dr. Jitender Sareen: In small communities, there's been clear evidence that there have been suicide contagion effects, where multiple people have died based on one person dying. That's been—

Hon. Pamela Wallin: Do you think that would be a condition in the context of MAID?

Dr. Jitender Sareen: I do believe that, yes.

The Joint Chair (Mr. René Arseneault): Thank you, Ms. Wallin.

The last question will be asked by Dr. Ravalia.

You have three minutes.

Hon. Mohamed-Iqbal Ravalia: Thank you, Chair.

Thank you, Dr. Sareen, for your testimony.

I'm just curious. You're seven of 17 chairs who have made this statement. Have you had any dialogue with the other 10 chairs who represent psychiatric associations about what their point of view may be?

Dr. Jitender Sareen: Today's testimony is from eight chairs out of 16 right now. One department doesn't have a chair.

Yes, we've had lots of discussion around this issue. There are a variety of political reasons the other chairs are not here, but they were part of the statement that was made last year, and the issues we brought up last year have still not been resolved.

Hon. Mohamed-Iqbal Ravalia: Two of the largest psychiatric associations in Canada—the Canadian Psychiatric Association, with approximately 2,500 members, and the Quebec Psychiatric Association, with approximately 1,200 members—have both taken the position that people with mental disorders should have the same rights as people affected by other medical conditions. Would you be able to comment on that point?

Dr. Jitender Sareen: I just want to add that when CPA testified two weeks ago, they said that they had not been fully supportive of MAID. They talked about the idea of equity, but we addressed in our comments that equity doesn't mean equal treatment. The majority of the surveys done have shown that the majority of psychiatrists are not in favour of MAID for mental illness.

Hon. Mohamed-Iqbal Ravalia: I want you to speak to the 2% of psychiatrists and 2% of other clinicians, including medical doctors and nurse practitioners, who have signed up and completed module seven of the national standards and are now proceeding and willing to explore the issue of MAID in individuals with mental illness.

Dr. Jitender Sareen: Again, there's controversy on this issue. What we're trying to provide here is scientific evidence around determining and differentiating suicide from MAID and around irremediability. We don't agree with the fact that people with mental illness should have access to MAID when there are potential treatments that can help them recover.

Hon. Mohamed-Iqbal Ravalia: We've heard from expert witnesses that suicidality is actually a clear exclusionary factor for individuals seeking MAID, and that these assessments are intense and deep, multifactorial, and often take a significant period of time.

In your own practice, have you ever come across a clinical situation where you've tried absolutely everything within current base standards and were not able to provide a responsible approach to improving that individual's mental illness?

Dr. Jitender Sareen: There are cases that suffer, but the idea is to sit with somebody who is depressed and hopeless and help them with their recovery.

[*Translation*]

The Joint Chair (Mr. René Arseneault): We now go to Senator Martin.

[*English*]

The floor is yours for three minutes.

● (2125)

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

Dr. Sareen, psychiatry is a very specialized field and practice, but I know that we don't have enough across the country, so the Health Canada health standard, I believe, does not require that the MAID assessor be a psychiatrist.

What are your thoughts on that?

Dr. Jitender Sareen: Again, we are very concerned about that because psychiatrists are extremely important in assessing suicidality and depression, as well as treatments. Even in addictions, people often have an underlying mental disorder, like post-traumatic stress disorder or depression, and that can be missed. Psychiatrists are also involved in second- and third-level treatments beyond medications. Therefore, we're very concerned.

An example would be somebody who has a brain tumour. Although there are a limited number of neurosurgeons, a neurosurgeon has to make the time and effort to help assess.

We strongly believe that psychiatrists have to be part of the assessment process.

The Joint Chair (Hon. Yonah Martin): You haven't seen the CAMAP module seven, the training module. Is that correct?

Dr. Jitender Sareen: I have not.

The Joint Chair (Hon. Yonah Martin): I am curious about what that would look like from your standpoint as a psychiatrist. I'm assuming that psychiatrist specialists would have been part of its development. However, you haven't seen it.

Is it possible for me to ask Dr. Gagnon a question? It's a simple one: Is there consensus among Quebec psychiatrists that we are ready to move forward with MAID for mental illness?

[*Translation*]

Dr. Pierre Gagnon (Director of Department of Psychiatry and Neurosciences, Université Laval, As an Individual): I'm going to answer in French, if that's all right.

No, there isn't a consensus. That is why the National Assembly of Quebec decided not to expand MAID to individuals whose sole medical condition was a mental disorder. Quebec went through that whole debate, and obviously, the Association des médecins psychiatres du Québec had a say, among others.

What Dr. Sareen just said is absolutely true. The same thing was said in Quebec. We can't move forward with this right now. We aren't ready. That is why the National Assembly of Quebec chose not to even put the issue on its agenda. It's too complicated. The issue is controversial among patients, families, members of the public, psychiatrists, politicians and so on.

It's something that requires lengthy study. That's why Dr. Sareen called for an indefinite pause on the measure. It's extremely complex and causes controversy on every level.

The Joint Chair (Mr. René Arseneault): Thank you, Dr. Gagnon.

Thank you to all the witnesses.

At the request of your joint chairs, we are going to move in camera to quickly discuss committee business, since we don't have a lot of time left.

Go ahead, Mr. Cooper.

[*English*]

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

I would like to move a motion: That the committee order the immediate production of the CAMAP curriculum module seven, “MAiD & Mental Disorders”.

Let me just very briefly comment, if I may, with respect to the motion that I've now moved.

We have been, as a committee, repeatedly told to trust the CAMAP curriculum, that it is robust and that we can have the assurance that the training is of the highest quality possible. A key question on the issue of whether are we ready for MAID and mental illness is the question of irremediability, being able to accurately predict irremediability, as well as distinguishing between a rational request for MAID and suicidal ideation.

CAMAP was asked three times, by me, to provide the criteria in their curriculum. They were unable to do so. They were unable to do so when Senator Martin followed up. They said it's all very complicated and it's a case-by-case basis. That is precisely what the expert panel said, and it is precisely the reason that the chairs of psychiatry wrote a letter calling on the government to delay the implementation of MAID for mental illness, which would have come into effect in March 2023. It was very disappointing that when CAMAP was asked about providing the curriculum to the committee, this was met with reluctance.

Mr. Chair, this committee, as a standing committee, has the power to compel production of documents. Unless CAMAP can point to a specific provision, by way of legislation, that would protect them from providing this committee with that curriculum, they must do so if this committee adopts such a motion; otherwise, they will be in contempt of Parliament.

Given the seriousness of the issues at hand and the degree to which this curriculum is being relied upon to justify to this committee that we're ready for MAID and mental illness, CAMAP has an obligation to provide this committee with that curriculum. It ought not be one big secret.

● (2130)

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

Senator Wallin, go ahead.

Hon. Pamela Wallin: I don't think it's a secret. I think it's the workings of a professional body, so I would move an amendment to say that those documents would be viewed only in camera and not accessible to the public at large.

The Joint Chair (Hon. Yonah Martin): There is an amendment to your motion.

Mr. Michael Cooper: I don't support it, but she has every right to move the amendment.

The Joint Chair (Hon. Yonah Martin): Senator Wallin has moved an amendment to the motion that it be viewed in camera and is not for public consumption.

Is that agreed, or do we need a recorded vote?

Mr. James Maloney: Can I just make a comment?

The Joint Chair (Hon. Yonah Martin): Yes, you can, Mr. Maloney.

Mr. James Maloney: I don't think we need to overly complicate this thing. I agree with Mr. Cooper, but I agree with Senator Wallin, too. I think it's important that we get access to the document—to the extent there is a document or whatever it is—but there may very well be legitimate reasons that this isn't a public document. I don't know that there are any, but I just think we should tread cautiously in case there are, rather than forge ahead blindly.

The Joint Chair (Hon. Yonah Martin): Mr. Cooper, are you in agreement?

Mr. James Maloney: We're all agreeing here. I just don't want to walk into something blindly. That's all.

Hon. Pamela Wallin: Do we have agreement on the amendment, then?

The Joint Chair (Hon. Yonah Martin): Go ahead, Mr. Cooper.

Mr. Michael Cooper: Thank you, Madam Chair.

I am somewhat reluctant to agree to the amendment put forward by Senator Wallin, but I think there seems to be agreement that at least getting the curriculum is something that would be appropriate for this committee.

In that spirit, I would accept Senator Wallin's amendment.

The Joint Chair (Hon. Yonah Martin): Are we all in agreement with the amendment to the motion?

(Amendment agreed to)

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

The amendment has been adopted. Now we are on the main motion.

(Motion as amended agreed to [*See Minutes of Proceedings*])

The Joint Chair (Mr. René Arseneault): We will turn this meeting to an in camera meeting. The co-chair asked to share some information on committee business.

We'll suspend temporarily just to—

Mrs. Shelby Kramp-Neuman: Can I ask that we just stay open?

The Joint Chair (Mr. René Arseneault): It's for committee business.

Hon. Pamela Wallin: Can you give us a timeline? The Senate is still sitting, so we're just trying to get back to work here.

The Joint Chair (Mr. René Arseneault): It's going to take a maximum of five minutes.

Mrs. Shelby Kramp-Neuman: Is it with regard to briefs or timelines?

● (2135)

The Joint Chair (Hon. Yonah Martin): Yes.

Mrs. Shelby Kramp-Neuman: We could probably move quickly in the open, if that's agreeable.

The Joint Chair (Mr. René Arseneault): We will go in camera. Agreed? Okay.

[*Proceedings continue in camera*]