Canadian Mental Health Association's Position Paper on Medical Assistance in Dying (MAiD)

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The Canadian Context - **Overview of Bill C-14**

On April 14, 2016, Bill C-14 (the Bill) received first reading in the House of Commons of Canada and was formally passed into law on May 30, 2016. The Bill primarily sets out to decriminalize medical assistance in dying (MAiD) by amending portions of the Criminal Code that otherwise prohibit it. Additionally, it addresses eligibility and procedural elements of MAiD. The Bill follows the Supreme Court of Canada 2015 decision in Canada v. Carter, which legalized MAiD in Canada by striking down the Criminal Code provisions associated with the act.

Beyond providing detailed eligibility criteria, the Bill is most notable for its definition of 'grievous and irremediable' medical condition that includes a "reasonably foreseeable natural death". The Bill aims to maintain the Criminal Code's prohibition of assisted suicide, while creating an exemption for MAiD so as to protect medical practitioners. The counselling or assistance of suicide remains against the law in any circumstance outside of MAiD. Importantly, criminal sanctions are outlined for medical or nurse practitioners that do not comply with the procedural requirements set out in the Bill, acting as a key safeguard for ensuring the responsible implementation of this legislation. The Bill will amend the *Criminal Code of Canada, the Pension Act, the Corrections and Conditional Release Act*, and the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*.

Bill C-14 does not, however, explicitly include mental illnesses in the eligibility criteria. The Bill provides a narrow definition of a 'grievous and irremediable' medical condition:

(s.241)

Grievous and irremediable medical condition

A person has a grievous and irremediable medical condition if

A. they have a serious and incurable illness, disease or disability;

B. they are in an advanced state of irreversible decline in capability;

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

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

The first criterion uses the word 'incurable', which could easily exclude most mental illnesses based on the availability of treatment and recovery-based philosophies of mental health agencies such as CMHA. Subsection (b) requires a 'state of irreversible decline in capacity', which would also likely exclude mental illnesses, as they often fluctuate in symptoms and are remediable with appropriate treatment. Finally, Subsection (d) requires that a natural death be reasonably foreseeable, subsequently setting a very high threshold that will not likely be met solely on the basis of a mental illness.

In legalizing physician-assisted dying in the *Carter* decision, the Supreme Court indicated that its intention was to address a very small number of eligible patients. The Supreme Court found that there was no evidence to show that physician-assisted dying had negatively impacted vulnerable populations in other jurisdictions where it is legal, nor was there an increased risk of people with disabilities wanting to access it. The ruling allows for competent adults living with a "grievous and irremediable medical condition that causes enduring and intolerable suffering" to end their

life with the assistance of a physician. The Supreme Court did not, however, define "grievous and irremediable," raising the questions of whether or not mental illnesses and addictions can be defined that way and what the implications of doing so would be in this context.

End-of-life care is a relevant issue to all Canadians, meaning that the regulation of this new law must adequately address the needs and well being of a diverse and complex population. The questions surrounding mental health are complex ones, requiring careful navigation in order to properly address people living with mental health conditions. While there may be some question as to whether mental illnesses can be included in the term "grievous and irremediable medical condition," it is our position that the Supreme Court of Canada specifically distinguished their ruling from the laws of other countries such as Belgium which includes "euthanasia for minors or persons with psychiatric disorders or minor medical conditions" (para. 111 of Carter). This very important distinction attempts to distance Canada's legal framework on this issue from other nations that have raised controversy due to their broad policies and administration of the practice. Upon comparison of other jurisdictions that allow for psychiatric- Euthanasia/Assisted Suicide, CMHA's position that mental illness not be included in this definition becomes clear.

Other Jurisdictions – **A Case Review of the Netherlands and Belgium**

As Canada continues to debate the particularities of the legalization of MAiD, it is important to look towards our international neighbours who have forged the way before us. Beyond Canada, euthanasia or assisted suicide (EAS)[1] is now legal in some form in Belgium, the Netherlands, Switzerland, Luxembourg, and several American states.[1] In regards to this report, however, it is essential to analyze the countries that have legalized EAS for non-terminally ill patients suffering *solely* from mental illnesses. Here, we will assess this practice in the Netherlands and Belgium, focusing on data from two specific studies that analyzed cases of psychiatric EAS within their respective countries.

The Netherlands (NL) and Belgium (BE) have constructed a set of "due care" criteria that must be met for EAS to be legally performed. The most striking difference between their standards and the Canadian law is that death need not be foreseeable to perform EAS in the Dutch and Belgian cases, hence why psychiatric- EAS may be performed. Tinne Smets et al. have organized the Dutch and Belgian substantive and procedural requirements as follows:[2]

- The patient's request must be voluntary and well considered; it must be repeated, and may not be the result of any external pressure (BE/NL).
- The patient must be in a medically futile state of constant and unbearable physical or psychological suffering, which cannot be alleviated, resulting from a serious and incurable condition caused by illness or accident (BE).
- The patient's suffering must be lasting and unbearable (NL).
- The physician must inform the patient about his/ her health condition and prospects (BE/ NL).
- The physician must terminate life in a medically and technically appropriate way (NL).

[1] Note: EAS is the term used interchangeably in the Belgium and the Netherlands context, while in Canada MAiD is used; however, both terms are referencing physician-assisted death.

- The treating physician must consult another physician before proceeding (BE/ NL).
- The physician must notify the case of euthanasia for review (BE/ NL).

Beyond these official, legislative similarities, it is important to highlight the social, normative similarities as well. In both countries, psychiatric-EAS appears to be on the rise—Since 2006 it has increased by an average of 15% a year, nearly three times the 2002 figure [meaning] that today about one in 25 deaths in the Netherlands is the result of psychiatric-EAS.[8] Similarly, a Belgian statistic claims that, since 2002, the number of EAS reported deaths has increased each year, "rising from 742 in 2004/2005 to 2086 in 2010/2011," although it should be noted that this may also reflect better reporting.[9] The social normalization of this practice is alarming upon realization of the systemic flaws highlighted by the Belgian and Dutch studies that analyzed psychiatric EAS cases in both countries.

Through a comparison of the two studies conducted by Lieve Thienpont et al. (2015) in Belgium and Scott Kim et al. in the Netherlands, some issues with EAS reporting become clear. The Belgium study analyzed 100 cases of EAS requests, procedures and outcomes between 2007 and 2011, while the Dutch study compared 66 cases of *completed* EAS cases between 2011-2014. While the Dutch study is null here as all procedures were completed, the Belgian study highlights important findings in psychiatric EAS— mentally ill patients have a high likelihood of *changing their minds*. Out of the 48 patients who were approved for EAS, 11 (excluding 1 patient who postponed due to imprisonment) either postponed or cancelled their procedures.[10] Additionally, of the 52 patients who were not accepted, 38 withdrew their requests before a decision was made.[11] Therefore, 48% of patients (38 withdrew + 10 who postponed) in this study changed their minds. This is a concerning statistic as it reveals the high likelihood that, with more time and support, a patient requesting psychiatric EAS may retract their decisions. Follow up data collected a year later further supports this claim: Of the 57 patients who were still alive (35 died by EAS, 6 by suicide, 2 by other health issues), only 9 patients still had EAS requests being processed.[12] Meanwhile, in the remaining 48 patients, "their requests were on hold because they were managing with regular, occasional or no therapy".[13] These patients who were successfully coping and functioning, just one year later, may have otherwise already died due to the practice of psychiatric EAS. Most patients suffering with depression or other psychiatric disorders may struggle to find coping techniques for long periods of their lives; however, our position is that death need not be the solution. This study suggests evidence of this, highlighting that psychiatric EAS requests may be part of the natural symptoms of many mental illnesses, particularly depression. In fact, "depression is more influential on the desire to hasten death than physical pain".[14] And, where a desire to die is often part of a patient's disorder, "the competence of [a] decision and the intractability of their suffering are much more difficult to assess".[15] It is difficult to justify supporting a "wish to die" if that wish is a known symptom of a patient's mental illness and if said symptoms are treatable.

CMHA also notes the changing social norms in Belgium and the Netherlands surrounding this issue. The increases in requests of psychiatric-EAS may be attributed to "continuing attitudinal and cultural shifts; values of autonomy and self-determination have become more prominent, and acceptance of euthanasia continues to increase in the population at large".[16] After the Dutch data revealed that 20% of patients had never had psychiatric hospitalization, that there was a high ratio of women to men (2.3 to 1), and that social isolation and or loneliness was a key observation in 56% of the reports, [17] a red flag was raised: psychiatric-EAS may intersect with larger social issues. We must be careful to avoid the use of psychiatric-EAS as a "substitute for effective psychosocial intervention and support".[18] However, while psychiatric-EAS may be on the rise, it still remains an unfavourable option to the majority of the population. A Dutch survey (2012) revealed that a minority of healthcare professionals (35-36%) and the general public (28%) agreed with providing EAS to patients with chronic depression.[19]

Upon analysis, it is clear that the existing state policies on psychiatric-EAS in Belgium and the Netherlands allow for substantial gaps in their standards and compliance mechanisms. The Dutch and Belgian data validates CMHA's position that psychiatric-EAS does not have a place in the current Canadian context.

Canadian Mental Health Association (CMHA) – Our Vision, Mission and Values

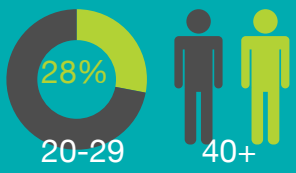
Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive community mental health organization in Canada. Through a presence in hundreds of neighbourhoods across every province, CMHA provides advocacy and resources that help to prevent mental health problems and illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive.

Visit the CMHA website at www.cmha.ca.

Mental Health and Recovery

Mental health affects us all and mental health conditions may occur across the life span, regardless of gender, race, sexual orientation or other social factors. For numerous reasons CMHA believes that psychiatric-MAiD should remain illegal, the most important of which is the core belief that any such mental health condition is treatable, recovery is always possible, and that in order to be inclusive, a society must support people with mental illnesses and addictions.

One in five Canadians experiences a mental health issue in any given year.[20] Currently, more than 6.7 million people are living with a mental health condition in Canada.[21]



More than 28% of people aged 20-29 experience a mental illness in a given year, and by the time people reach 40 years of age, 1 in 2 people in Canada will have had or have a mental illness.[22]

i. Belief in Recovery

Recovery is the process by which people with lived experience of mental health and addictions issues gain control, meaning and purpose in their lives. Recovery is a unique, personal experience, involving different paths for different people. For some, recovery may mean the complete absence of the symptoms of a mental illness while, for others, recovery entails developing effective coping strategies for ongoing symptoms in an effort to maintain an active, full life within the community.[23]

Many mental health and addictions services and supports now promote recovery-oriented philosophies in their practices. Growing evidence shows that people can and do improve and recover from mental illness and addictions, effectively renouncing the outdated medical assumptions that mental illnesses only worsen over time. Now, new and more effective medical, social and community services and supports have been developed and implemented with the goal of recovery at the forefront.

Recovery involves changes in the way individuals with mental health and addictions conditions think, act and feel about themselves and their lives. It also requires changes in the ways services are funded and organized, mental health professionals are trained, and success is measured. Recovery is about transforming the mental health and addictions system so that it truly puts the person at the centre.

ii. Loss of Hope

It is important to discuss the potentially negative impact of a psychiatrist's or medical practitioner's approval of MAiD for their patient. Presenting MAiD as a viable option may "reinforce loss of hope and demoralization"[24] in struggling patients. It is argued that, "by answering a death request of a psychiatric patient positively, a central therapeutic element in the doctor-patient relationship, namely the instrument of hope, is removed".[25] Also related is the argument that these discussions "about the possibility of (assisted suicide) between doctor and patient may reinforce feelings of desperation and demoralization in the patient". The doctor-patient relationship is of key importance as patients often look to their doctors for answers. If the doctor—the patient's advisor and power figure—agrees or supports the

wish to die for reasons of mental illness, it is an indirect admission that the patient will never recover and that they cannot recover from their mental health condition. As CMHA firmly believes in recovery and the treatment of mental illnesses and addictions provided the proper supports and resources, this "loss of hope" is considered very detrimental.

iii. Non-discrimination

Similar to the discussion surrounding parity, CMHA supports that non-discrimination between mental illness and physical illness be upheld. If a patient with a reasonably foreseeable natural death *also* has a mental illness, that mental illness should not preclude them from being able to access MAiD. Whether or not the patient was afflicted by a mental illness before or after the physical illness, in an effort to prevent discriminatory practises in public health, the physical illness must take precedence if it meets the eligibility criteria as put forth by bill C-14.

Our Position

As a recovery-oriented organization, CMHA does not believe that mental illnesses are irremediable, though they may be grievous or unbearable.

We recognize that people with mental illnesses can experience unbearable psychological suffering as a result of their illness, but there is always the hope of recovery.

CMHA's position on medical assistance in dying in Canada, is that people with a mental health problem or illness should be assisted to live and thrive.

Recommendations

As a recovery-oriented organization, CMHA makes the following recommendations to the Government of Canada:

1. Support Recovery

CMHA believes that every person living with mental health and addictions issues must be actively supported in their journey of recovery. With the right supports and resources, research suggests that recovery is possible regardless of the mental health diagnosis.[26] Recovery-oriented practice, or one that places the patient at the centre of care, is essential for a high performing mental health and addictions system in Canada.

2. Continue to invest in community mental health and addictions services and supports

We need governments to ensure there is access to a full continuum of mental health services and supports for all Canadians, in all communities across Canada. Although there have been significant new investments in mental health and addictions, Canada still lags behind all of the other G7 countries. Before we assist people in dying, we should assist people to live and thrive – this starts with making sure that all Canadians have equitable access to mental health and addiction services. The overall well-being and resilience of Canadians with lived experience of mental health issues will improve if their basic needs for income security, affordable and safe housing options, and opportunities to secure supported employment are met; and if a range of community-based, traditional and/or alternative mental health and addictions services and supports are available to them.

Equity

- It is well established that some groups (or populations) in society experience social and economic disadvantage – inequities – due to the unequal distribution of power, wealth and resources. The social determinants of health both determine and deepen inequities.
- Marginalized groups are more likely to experience poor mental health and in some cases, mental health conditions. In addition, marginalized groups have decreased access to the social determinants of health that are essential for recovery and positive mental health.
    - Our marginalized communities are at a greater disadvantage in terms of access to care compared to non-marginalized groups. The principles of equitable provision must inform our mental health and addictions system.

3. Develop a national suicide prevention strategy

Though Canada has a national mental health strategy, *Changing Directions, Changing Lives: the Mental Health Strategy for Canada*[27], we currently lack a comprehensive suicide prevention strategy. A national strategy for suicide prevention is necessary to coordinate the existing suicide prevention efforts currently underway in provinces and territories across Canada, and to bring evidence-informed practices for suicide prevention to every community in our country. CMHA recommends that a national suicide prevention strategy be developed to promote mental health recovery for all Canadians.

4. Invest in research to accurately predict and understand the course of illness in mental health and substance use

Our understanding of mental health and addictions issues and our implementation of practises/solutions, are quite underwhelming. There is a shortcoming here that needs to be addressed and we encourage investment in research to better understand these issues.

Approved by the Canadian Mental Health Association National Board of Directors, August 2017

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End Notes

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2 Tinne Smets, et al., "The medical practice of euthanasia in Belgium and the Netherlands: Legal notification, control and evaluation procedures," Health Policy 90 (2009): 182.

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8 Theo A. Boer, "Euthanasia in the Netherlands: An Eyewitness Report," *Human Life Review* 41 (2015): 61.

9 Thienpont et al., "Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders," 3.

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