When Mental Health Meets MAiD: Expanding Medical Assistance in Death to Mental Health

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EXECUTIVE SUMMARY

Beginning March 17, 2027, medical assistance in dying (MAiD) will expand eligibility criteria to mental illness, meaning that those illnesses can be the sole condition to qualify for MAiD (Government of Canada, 2024). In Canada, the *Criminal Code* prior to 2015 was inconsistent with *Charter* rights, mainly those written in section 7, and was amended to allow MAiD after the Supreme Court of Canada decision in *Carter v. Canada* (Government of Canada, 2024). Though medically assisted death in Canada has yet to include mental health, in the eight jurisdictions that have legalized MAiD to some degree, [five] of them allow that an individual can access MAiD with mental illness being the only health condition (Mehlum, et al., 2020). The authors originally stated that six jurisdictions allow medically assisted death to be available to those suffering from mental illnesses, with one of those jurisdictions being Canada, which has since been delayed through C-39. This action to delay inclusion of mental illnesses to MAiD presents the Canadian legislative body with a unique question: how can MAiD be expanded to mental health so that it may ensure proper administration of medically assisted death?

Mental health and illnesses exist on a wide spectrum, having different levels of treatment depending on the severity of disorder. For example, treatment for an individual suffering from ADHD differs greatly from someone suffering from depression. However, some mental disorders cause a great deal of mental anguish and suffering that options to terminate one's life becomes a viable option of treatment. This option only exists at the extreme end of treatment, being that it presents a permanent solution. Because of this, the need to properly evaluate certain mental illnesses and disorders is an issue that the federal Government of Canada is faced with in medically assisted death; an individual suffering from anxiety--'low' in terms of mental health severity--should not be able to seek out MAiD as a means to alleviate themselves of their

condition. In the case of Canada's existing MAiD laws, 'grievous and irremediable suffering' is defined as a condition that causes great physical and psychological suffering, and is incurable (Government of Canada, 2024). This definition is part of the eligibility criteria in order to receive medically assisted death (2024). With mental health continuing to garner support in contemporary politics, the need to expand MAiD to mental disorders is also starting to gain importance.

Bill C-7's impact on MAiD opened the door to receiving medically assisted death when death is not reasonably foreseeable. Prior to 2021, MAiD was only available to those with physical conditions, who had grievous and irremediable suffering, and their death was reasonably foreseeable. The policy of expanding MAiD to mental health will also fall under this scenario of seeking out medically assisted death.

The policy recommendation outlined in this paper will have to be an amendment to the *Criminal Code*. Section 241.2 of the C*riminal Code* outlines the regulations in carrying out medically assisted death in Canada, and the exclusion of mental health is explicitly stated in subsection 2.1 (*Criminal Code, 1985*). The first steps in expanding MAiD is to rewrite the provisions in subsection 2.1, stating that those with mental health disorders are eligible for medically assisted death. However, not only should subsection 2.1 be rewritten, all the other sections regarding MAiD must be lengthened to include provisions for mental illnesses.

When MAiD is expanded in Canada to include mental health in 2027, there should be robust safeguards in place that will help protect society's most vulnerable population; MAiD should not be the first option of treatment. Because medically assisted death is an amendment under the *Criminal Code*, the safeguards and policy recommendations that this paper will outline are addressed to the federal government of Canada. MAiD should not be accessible to those

suffering with ‘low’ severity mental illnesses, and should only be available to those who have proven that their mental disorder creates barriers and hinders their day to day lives. The policy that will be recommended to the federal government of Canada is to adopt the system of MAiD that exists in the Netherlands: due care must be carried out; there must be a physician consulted who has expertise on the mental illness of the individual who is requesting MAiD; and there must also be a separate division in healthcare services populated by mental illness experts and physicians that are trained in handling and assessing MAiD requests to ensure proper care is met. This differs from the original policy recommendation which reflected the Belgian system, which only requires a third opinion from a physician who has expertise in the mental illness of the patient. Upon further analysis of Belgian practices in administering MAiD, the evidence suggests that the system is inadequate. Further examination regarding both jurisdictions using empirical evidence is done later in the paper.

This paper will first go over the literature that surrounds medically assisted death and the concerns of expanding MAiD to mental health. A review of the moral and ethical concerns of mental health in medically assisted death will be outlined to aid the implementation of proper legislation to expand MAiD. After, a review of the best practices and evaluation across multiple jurisdictions will also be conducted. The reason for reviewing best practices is to help gain a better understanding of how MAiD is implemented in other jurisdictions so that the Canadian federal government may look at policies where MAiD is successful and where it is not, and how they may avoid failures in implementation in 2027. A final policy recommendation consisting of 2 options will then be made after the review of best practices.

It must be stated that the policy options being made and recommended do not provide a classification or evaluation process that groups mental illness severities, categorizing them from

‘low’ to ‘high’; that is the duty of the division which will handle MAiD-MC requests. This recommendation merely exists as a framework that professionals can use through their expertise to evaluate mental health. Whatever is categorized as a mental illness having ‘low’ severity in this paper is being done using general and basic knowledge of mental conditions, rather than having a nuanced background of said illnesses.

LITERATURE REVIEW

Current MAiD laws outline ways that individuals can seek out medically assisted death if their death is reasonably foreseeable and not reasonably foreseeable (*Criminal Code of Canada,* 1985). These laws also ensure that other forms of treatment are reviewed before a decision is made (1985). The moral concerns of MAiD and mental illnesses look over the termination of life where death is not reasonably foreseeable. Much of the literature surrounding medical assistance in dying where mental health is the sole condition (MAiD-MC) is regarding these ethics. Medically assisted death is permitted under the circumstances that their condition is serious which causes a decline in life capability, while also causing suffering that affects the individual both physically and psychologically, known under the *Criminal Code* as a ‘grievous and irremediable condition’ (*Criminal Code of Canada,* 1985). Those seeking out MAiD understand the gravity of their condition, and this type of care seems to be the only viable treatment for their health. Conversely, MAiD-MC arguments go beyond the legal framework laid out in *Carter v. Canada*.

The opinion of the Supreme Court held that not allowing assisted death impeded on legal rights, specifically the right to bodily autonomy, being that the condition of the individual could perhaps have gotten worse which would have severely impacted their ability to end their life at a more ‘reasonable’ time (Carter v. Canada, 2015). Though this line of argument leads scholars to

believe that MAiD-MC does not adhere to the decisions made in *Carter*, as the mental illnesses are not terminal, with their sole argument being that one who "retains the physical and mental ability to end his or her own life and who is not dying takes MAiD into a different ethical and constitutional framework than argued in Carter" (Simpson, 2017, pg. 81). The decision in *Carter* dealt with an individual with a terminal physical condition that would have gotten worse and impacted their ability to make a decision to end their life before the condition worsened, whereas mental disorders do not have the same characteristic; it is difficult to ascertain the terminal status of mental illnesses and mental health. Simpson does not downplay the severity of mental illnesses, stating that mental disorders affect the day to day wellbeing of an individual, but argues that mental health does not deprive one of the ability to end their own life, and asserts that recovery is always a possibility. Not only is recovery an option, Simpson also posits that it should be the only option, being that those suffering with mental illnesses have the capacity to seek a better life with the condition that they have. The ethical concerns that Simpson addresses are ones that question the higher duty of professionals in healthcare: if their duty is to protect and uphold lives, when do they get to decide that some lives are not worth protecting, especially in psychiatry? Being a healthcare professional comes with an oath to protect and save lives, and MAiD breaks the oath of all doctors and nurses. Simpsons underscores the duty of healthcare, and their vow to protect lives, not to take them.

Many scholars in MAiD, much like Simpson, underline and study the moral concerns of medical assisted death, but also expanding its eligibility where mental health can be the sole underlying condition. Writing from many differing perspectives, Grassi et al. further illustrates the moral dilemma at hand: healthcare professionals preserving life versus their duty to relieve one's suffering through MAiD (2022). The dilemma looks at the difficulty of determining the

irremediability of mental illnesses: “whether a disorder is irremediable in a somatic disease (e.g., advanced stage of cancer) is quite clear, it is not so clear in mental disorders, since irremediability is difficult to be predicted” (2022, pg. 328). Mental disorders are difficult to determine if they truly impact a person’s capabilities the same way a physical ailment does. In addressing the concerns of extending MAiD to mental health, Grassi et al. states that determining irremediability also comes with its set of questions: should MAiD be acceptable across all mental disorders and illnesses; would it be discriminatory to deny MAiD in one case and accept it in another? (2022). The example of cancer that Grassi et al. gave helps illustrate the immense difficulty in looking at the irremediability of mental disorders, as PTSD may not have the same objective irremediability as the aforementioned disease.With many physical conditions, one can determine its irremediability fairly easily, with diseases such as Parkinson’s or amyotrophic lateral sclerosis having no viable cure. However, the same cannot be said for an individual suffering from PTSD, as there exists treatment where one can expect to recover.

Simpson argues that treatment, and subsequent recovery, is always a possibility in treating mental health, and Grassi et al. question the validity of MAiD-MC when difficulty arises in determining severity of mental disorders. What these authors fail to recognize is that, much like physical illnesses, mental illnesses also come with corresponding severities. One can determine the severity of mental illnesses through psychiatric evaluations, being those illnesses range in a spectrum from mild to severe impairment (Mental Illness, 2025). The moral and ethical dilemmas that surround MAiD cannot be understated, but in only arguing the morality behind deciding when a life ends denies an individual of legal rights that were set out in *Carter*. The goal of expanding MAiD to mental health is accompanied by the task of evaluating when a mental illness creates such suffering that, although capacity is expected to continue, the condition

causes psychological distress as written in the *Criminal Code*. In *Carter*, not allowing one to end their life at a more 'reasonable' time ran the risk of their conditioning worsening to a point where they no longer had the capacity to end their life. Though the individual in *Carter* was suffering from a physical ailment, the current laws on MAiD can also apply to mental illnesses. Authors of MAiD dissect the ethical dilemma of such a statute, but overlook the task of evaluating if a mental illness can cause intense personal harm to individuals.

Grassi et al. break down alternate arguments, stating that where there are cases that MAiD-MC is morally acceptable, mental illness in general can be the sole underlying condition because "prolonging an unacceptable or unbearable life, marked by agony and loss of dignity, is immoral" (2022, pg. 328-329). Though this view also looks at the morality of denying MAiD, it still ignores the possibility of evaluating the extent of one's disorder. Simpson emphasizes that recovery for mental illnesses is possible, and Grassi et al. detail the difficulty of determining the irremediability of mental illnesses. Mental illnesses can cause 'grievous and irremediable suffering' as outlined in the *Criminal Code*, being that these disorders can still cause distress and impact quality of life. For example, the mental illness of post traumatic stress disorder (PTSD). PTSD carries with it a plethora of symptoms that impact the quality of life of the individual, ranging from both physical and psychological distress (U.S. Department of Health and Human Services, n.d.). The possibility of recovery from PTSD and other mental illnesses can be a viable solution, but the issue in relying solely on recovery then creates a further dilemma: if and when a patient's condition worsens, would that inhibit their ability of seeking out MAiD-MC? *Carter* dealt with this dilemma. Applying the argument made by Grassi et al., denying an option such as MAiD inherently extends the pain that one feels.

Authors discuss the morality of permitting MAiD-MC, but do not discuss how these mental illnesses can be evaluated. This creates a noticeable gap in scholarly discussion of MAiD, being that evaluation itself can be hard. However, gaining a greater understanding of how jurisdictions can evaluate mental illnesses will be instrumental in enacting proper legislation that can aid vulnerable individuals. *Carter v. Canada* looked at the legality of denying medically assisted death in Canada, while authors have looked at ethical dilemmas, there needs to be discourse on how health services look at mental health and MAiD, and the best practices of evaluating levels of severity of mental illnesses in the same manner that physical conditions are evaluated.

The moral concerns and the dilemmas that accompany MAiD-MC cannot be ignored, however a growing number of jurisdictions are allowing that mental health be the sole underlying condition in seeking medically assisted death. These concerns can contribute to creating better safeguards in ensuring proper administration of MAiD-MC is done. Those who deal with mental illnesses make up the most vulnerable portion of society, so creating barriers that limit access to MAiD is paramount in protecting this population. MAiD-MC should not be sought out by someone who suffers from an eating disorder, a mental illness that is categorized as having 'low' severity. In developing a policy recommendation and looking at other jurisdictions that permit MAiD-MC, administration of such practices should not be given to just anyone that requests the service; MAiD is a permanent solution when all other options regarding treatment have been exhausted, so finding ways that limit the types of mental illnesses that receive MAiD is paramount.

POLICY BACKGROUND

In creating a system and policy recommendation for MAiD, it is important to overview Canada's current situation. As MAiD laws stand in Canada, there exist 2 different scenarios in the *Criminal Code*: where death is reasonably foreseeable, and where it is not. Referred to as 'tracks,' MAiD laws overview different scenarios in which one may seek out MAiD. Some tracks are already legal, as well as available in all provinces and territories. Track 1 of MAiD is where death is reasonably foreseeable, and that the physical condition is grievous and irremediable; this track is legal and available in all provinces. Track 2 of MAiD looks at scenarios where death is not reasonably foreseeable: where the individual's capacity is expected to continue, and where it is not. Capacity in this context refers to one's ability to request MAiD; for example, one may have such grievous and irremediable suffering that, in the future, their ability to request MAiD may be at risk. In cases where capacity is expected to continue, MAiD is legal and available across all of Canada. In cases where capacity is at risk, due to some physical condition that can affect one's mind such as dementia or Alzheimer's, MAiD is legal, but only in Quebec. *Truchon v. Procureur général du Canada* found it unconstitutional to deny MAiD because the plaintiffs did not fulfill the requirements in the *Criminal Code*: that death is reasonably foreseeable (2019). In response to this the Canadian federal government enacted Bill C-7 in 2021, expanding the eligibility requirement to individuals where death is not reasonably foreseeable, thus the creation of track 2. However, this scenario of track 2, while legal in Canada, is only available in Quebec because of the ruling by Quebec's Superior Court, and the rest of the provinces and territories have yet to implement it.

Of the tracks that have been examined, mental health is not mentioned as part of the eligibility requirements of MAiD, presenting the federal government with an opportunity to create a third track in MAiD with mental health as the sole underlying condition. This third track

will be under the scenario where death is not reasonably foreseeable, and capacity is expected to continue. Current legislation in Canada has pushed extending MAiD to mental health until 2027, so in the 2 years before then, the federal government has a limited amount of time to create a framework that safely expands MAiD to mental health.

REVIEW OF BEST PRACTICES AND EVALUATION

Before Canada enacts MAiD-MC there must be a proper overview of other jurisdictions in the methods that they enact medically assisted death. Safeguards must be put in place in order to create legislation that not only expands MAiD, but also does so in a way that can mitigate risks. There will be two criteria that will be used in assessing foreign MAiD policy that Canada can adapt: 1) there must be an independent, third party that evaluates and assesses the mental condition of the individual; 2) there must be less than 5% of all MAiD-MC cases of 'low' severity mental illnesses. This section will also function as a means of evaluating potential policies that Canada can adopt when MAiD is expanded to mental health in 2027.

Belgium is among one of the earliest jurisdictions to enact euthanasia laws, called *The Belgian Act on Euthanasia of May, 28th, 2002*. Belgium's Act sees considerable overlap between Canada's *Criminal Code* and its own legislation, mainly that MAiD must be voluntarily requested by an individual who is of legal age, without external pressure, while also a subject of grievous and irremediable suffering (De Hert, Van Assche, 2024). There are also safeguards in place where death is both reasonably and not reasonably foreseeable. Where Belgium deviates is that it allows MAiD to be sought where mental illnesses are the sole underlying condition, and much of its requirements mirror the physical conditions evaluation in Canada (2024). The "physical and psychological suffering" that is laid out in the *Criminal Code* is present in Belgium law as well: "the patient experiences constant and unbearable mental suffering that cannot be

alleviated" (s. 241.2, ss. 2(c) 1985, & De Hert, Van Assche, 2024, pg. 54). The "unbearable mental suffering" in Belgium law can also be the result of an incurable mental disorder (2024). The act also gives assessment criteria, as there must be 3 parties involved: the attending physician, 2 other independent physicians, one of which must be a psychiatrist, and a waiting period of 1 month between request and scheduled euthanasia date (2024).

Upon reviewing Belgium's Act, there are areas that Canada can adapt, mainly applying the same criterion between physical and mental illnesses. However, where Belgium missteps in their execution are the waiting periods, as well as which mental disorders were permitted to receive MAiD. In contrast to Belgium law, Canada has placed a waiting period of 90 days, instead of 30 in Belgium, although the waiting period in Canada may be shortened depending on severity of the patient's condition. The issue with having shorter wait times in MAiD does not allow the patient to have an adequate window of reflection for their decision. 30 days is far too short a period to think about ending one's life, considering the breakdown of deaths by MAiD-MC. Across a period of 20 years, 370 MAiD-MC deaths occurred; of those deaths, 55.7% were mood disorders, 4.6% were for autism, and 1.5% was for eating disorders (De Hert, Van Assche, 2024). The breakdown of MAiD-MC deaths in Belgium shows the somewhat lax psychiatric evaluations in Belgium. A person with an eating disorder should not be considered MAiD as an incurable disease, as it can be categorized as a mental illness that can be treated (Eating Disorders, n.d.). The other mental illnesses documented, such as mood disorders and autism, cannot be cured in the traditional sense. The nature of those mental illnesses cannot be avoided through any means of treatment. Individuals can live with autism or personality disorders, as they cannot cause any kind of intolerable psychological distress. However, under the Belgium system, they were seen as such. In western countries, autism and mood disorders are

common, with the general consensus being considered low severity. Allowing those types of mental illnesses to be eligible for MAiD is a weakness of the Belgium system. For Canada to properly adopt MAiD-MC, safeguards against these types of mental health should be put in place.

Another jurisdiction that allows medically assisted death is the Netherlands. Where the Netherlands differ from Canada is that assisted death is a punishable criminal offence if the physician does not meet the 6 criteria of due care, called the *Termination of Life on Request and Assisted Suicide Review* (Kouwenhoven, et al., 2018; van Veen, et al., 2022). Much like Belgium, the 6 due care criteria are generally the same eligibility requirements under the *Criminal Code*: the request is voluntary; there is unbearable suffering with no expectation of recovery; the patient is made aware of their situation; and a third, unbiased physician with no connection to the individual is consulted. A deviation of one of the 6 criteria from Belgium and Canada is that it places the physician in a higher role: the sixth criteria states that the physician must have performed euthanasia with care and respect to the patient (2022). Alongside the 6 due care criteria, when dealing with mental illnesses, there must be a second opinion given by an expert who specializes in the disorder of the patient (2022).

Recognizing the challenge of evaluating mental illness, a guideline written by the Dutch Psychiatric Association (DPA) outlines 4 phases in carrying out MAiD: request, assessment, consultation, and implementation (2022). Each of these 4 phases are essential in carrying out and administering MAiD: in the request phase, the patient expresses their wish for MAiD, but also to create a safe environment to discuss euthanasia while also determining if the patient is experiencing suicidality. In the assessment phase, the physician assesses all 6 due care while requesting a secondary expert opinion. The consultation phase sees the expert contacted; the

expert who is contacted is specially trained in MAiD requests, and organized in a separated branch of Dutch health services called ‘Support and Consultation for Euthanasia in the Netherlands,’ shortened to SCEN-physicians (2022). The last phase is implementation, where MAiD is carried out. The ways in which the Dutch system implements systems for psychiatric evaluation takes the lead on best practice.

Studying the number of cases for MAiD, van Veen et al. examine overall cases requested. They state that “56% of all Dutch psychiatrists have had a request for euthanasia during their career, and that about 95% of all requests are rejected” (2022, pg. 4). Alongside, they state that the volume of requests for psychiatric disorders are much higher than what is performed. The breakdown of psychiatric disorders was similar to what was found in Belgium: a majority of cases were dealing with depression and personality disorders, with anxiety and PTSD making up lower overall makeup. van Veen et al. state that around 90% of all requests for MAiD-MC were not fulfilled, stating further that “20% withdrew the request and 68% were rejected;” a majority those whose requests were granted aged from 50 to 60. (2022, pg. 4).

Where Belgium faltered in evaluating psychiatric disorders, the Netherlands seemed to have more intense and robust processes in carrying out MAiD. Nowhere in the study conducted by van Veen et al. does it state that eating disorders, autism, and mood disorders were the main condition for suffering; it did not reach over 50% of cases as it did in Belgium. This can be attributed to the more rigorous evaluation process of the DPA and its 4 phases of assessment. The reason that ‘low’ severity mental illnesses did not receive MAiD could have been due to the consultation phase. It is because of this organization where the Dutch system is very strong. Having an entire organization of doctors that review and are trained in MAiD and mental health is better for evaluation. Under the Belgian system, any kind of mental illness can seek out MAiD.

While the same can be said for the Dutch system, there is more rigorous testing and evaluation for mental conditions which also greatly protects vulnerable individuals.

Of the criteria that was laid out, the system in the Netherlands seems to have the best practice between the 2 jurisdictions for MAiD-MC. The reason being is that not only do they have a third party evaluating the patient's mental health, but a majority of the individuals that request MAiD-MC are rejected. While the number of 'low' severity mental illnesses was not mentioned by van Veen et al., the robust evaluations of the Dutch system should be looked at and emulated. Only 1 of the two criteria set out was fulfilled by the Netherlands, however the number of 'low' severity cases admitted to receive MAiD-MC in Belgium cannot be ignored. With this, the creation of a separate division that specializes in MAiD-MC requests outweighs the need to fulfill the second criteria. van Veen et al. showed that of the 1,308 cases requested, almost 90% were rejected (2022). The volume of requests that are rejected show that the Dutch system works in protecting mentally impaired people because not all mental illnesses qualify for MAiD-MC. It is inadequate that a single, third party physician who has expertise on the mental illness of the patient be the only evaluation process in handling MAiD-MC requests. The requests for MAiD and its implementation is extremely unforgiving, and any error within the processes can lead to disastrous consequences. When examining the Belgian process, there were too many instances that lead to 'low' severity mental illnesses receiving MAiD, whereas the system in the Netherlands has built barriers and safeguards which protect against such requests going through.

FINAL RECOMMENDATIONS

As discussed, Belgium's system of MAiD-MC is weak because it does not have any further evaluation processes, other than a third party. This was the original policy recommendation, however the flaws of this recommendation are too glaring to enact; there were

too many cases in Belgium where ‘low’ severity mental illnesses received MAiD. To strengthen the policy recommended, more should be added during the evaluation process. A third party is not adequate enough to evaluate mental illness. The process which the Dutch system uses should also be implemented into Canada: a division of the healthcare sector dedicated to MAiD-MC, populated by physicians who are trained in processing MAiD requests, while also having expertise in the mental illnesses that are seeking out medically assisted death. Not every request of MAiD-MC should be fulfilled at face value, but rather should be put through a rigorous process that evaluates and handles the delicacy of such requests. Under this framework, MAiD-MC would be carried out on a case-by-case basis, with each patient’s illnesses and conditions being handled with the utmost care and diligence so that they may receive proper care.

Of the two policy options examined, that of the Belgian and Dutch systems, the Dutch system is the recommended option. Its more robust safeguards ensure that not just any mental illness or condition receives MAiD, which is a glaring weakness of the Belgian system. The Belgian system cannot be recommended because of the lack of safeguards in protecting individuals with mental illnesses. The biggest strength of the Dutch system is its handling of the varying severity of mental illnesses; where Belgium treats mental illnesses as a single group, the Dutch system exercises greater scrutiny.

The next steps that the Canadian federal government must do is introduce 2 pieces of new legislation: 1) create a separate division in healthcare that processes MAiD-MC requests as well as adopting the Dutch system, and 2) amend the *Criminal Code* to remove the exclusions of mental illnesses. The second step will also require that the subsections within 241.2 be lengthened to include mental conditions. Those with mental illnesses are some of the most vulnerable in society and more prone to suicidal thoughts. By allowing society's most vulnerable

to seek out a more dignified death, the stigma around mental health will also weaken. It is also unfair that those who have physical ailments experience psychological suffering brought about by their condition are afforded more resources than those who experience the same suffering through mental illnesses. While MAiD-MC carries moral and ethical concerns, it has the capacity to protect as well. Society's most vulnerable deserve these resources so that they too may have the same care.

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