MEDICAL ASSISTANCE IN DYING AND MENTAL ILLNESS: WHEN THE ILLNESS HINDERING YOUR AUTONOMY IS THE ILLNESS YOU WISH TO BE RELIEVED FROM

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In 2015, the Supreme Court of Canada ruled that a prohibition on medical assistance in dying (MAiD) violated section 7 of the Canadian Charter of Rights of Freedoms, and that MAiD should be permitted for competent adults who consent, have a grievous and irremediable medical condition, and experience intolerable suffering. The federal government subsequently enacted legislation to regulate MAiD. The legislation introduced an additional requirement for MAiD – namely, that a natural death be reasonably foreseeable – and mandated that an independent review be conducted on the issues surrounding mental illness and MAiD. Although individuals with mental illness are permitted to request MAiD as long as they satisfy the eligibility requirements, access remains challenging for those who cannot meet the criteria but are nevertheless suffering from a serious illness.

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This article discusses how the current MAiD framework impacts individuals with mental illness as their sole underlying medical condition. It identifies as significant barriers to access the criteria that an individual’s natural death must be reasonably foreseeable and that he or she must have the capacity to consent. It then examines the advantages and disadvantages of broadening the eligibility criteria to increase access for individuals suffering from mental illness. In particular, this article demonstrates that the current eligibility criteria are not compliant with the Canadian Charter of Rights and Freedoms, because they exclude a large proportion of people who suffer from mental illness. The article concludes by providing recommendations and safeguards within what the author believes to be acceptable ethical parameters.

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INTRODUCTION

In 2016, Bill C-14, An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)¹, came into force in Canada. In public and parliamentary debates leading up to this Act, considerable attention surrounded the question of whether the presence of mental illness should be an exclusion criterion for access to medical assistance in dying (MAiD).² With the purpose of protecting the vulnerable, the legislation was enacted with a promise to later conduct an independent review of the issues surrounding mental illness and MAiD.³ A report on this review was released on 12 December 2018,⁴ but the option of MAiD remains largely unavailable to individuals with mental illness as their sole underlying medical condition, unless they satisfy stringent eligibility criteria.

MAiD represents a significant decision by an individual to end his or her life. Since mental illness can impair mental functioning, one of the primary controversies surrounding mental illness and MAiD concerns a person’s decision-making capacity. In particular, critics of MAiD point out that symptoms of mental illness may predispose individuals to make a request.

The purpose of this article is to take a deeper look at the range of issues surrounding MAiD, and whether it should be available to those with mental

¹ 1st Sess, 42nd Parl, 2016 (assented to 17 June 2016) [Bill C-14].

² See e.g. House of Commons Debates, 42-1, No 62 (31 May 2016) at 3797–98 (Hon Geoff Regan) [HOC Debate]; Debates of the Senate, 42-1, No 41 (1 June 2016) at 757–58 (Hone George J Furey) [Senate Debate 1]; Debates of the Senate, 42-1, No 52 (17 June 2016) at 1234 (Hon George J Furey) [Senate Debate 2].

³ See Bill C-14, supra note 1, s 9.1(1); “Medical Assistance in Dying” (12 December 2018), online: Council of Canadian Academies <www.scienceadvice.ca/en/assessments/in-progress/medical-assistance-dying.aspx> [perma.cc/A9J3-TQ53] (the Honourable Dr. Jane Philpott, former Minister of Health, and the Honourable Jody Wilson-Raybould, former Minister of Justice and Attorney General of Canada, announced on 13 December 2016 that the Council of Canadian Academies had been selected to conduct the independent reviews).

⁴ See generally Council of Canadian Academies, The State of Knowledge on Medical Assistance in Dying where a Mental Disorder is the Sole Underlying Medical Condition, The Expert Panel Working Group on MAID where a Mental Disorder Is the Sole Underlying Medical Condition (Ottawa: CCA, 2018) [CCA Report].
illness as their sole underlying medical condition and who do not meet all of the current eligibility criteria. In particular, this article argues that the current eligibility criteria are not compliant with the Canadian Charter of Rights and Freedoms because they exclude a large proportion of people who suffer from mental illness. To make the criteria comply with the Charter, the criteria should be amended.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) defines mental illness as a condition characterized by a disruption in regular mental functioning. Specifically, it defines mental illness as “[a] clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.” This term encompasses many different types of illnesses, including schizophrenia, borderline personality disorder, and anxiety. While some types will apply to certain sections of the analysis, others will not. The purpose here is to ask whether MAiD should be allowed for any of them. Further, while Bill C-14 required that independent reviews also be conducted on issues relating to advance requests and requests by mature minors, this article will focus exclusively on adults.

I recognize that “MAID” is a term specific to Canada and that prior to 2016, it was often referred to as “physician-assisted dying”. Terms used in other jurisdictions include “voluntary active euthanasia” and “physician-assisted suicide”. Since each generally encompass the same act, I use the term “MAiD” throughout this article.

To establish a foundation of why mental illness is viewed as a distinct condition, I begin with a comparative analysis of the distinctions between mental and physical illnesses. I then address whether individuals with mental illness can meet the eligibility requirements for MAiD established in the Criminal Code via Bill C-14. Finally, I analyse the advantages and dis-


7 See Bill C-14, supra note 1, s 9.1(1); CCA Report, supra note 4.

8 RSC 1985, c C-46 [Criminal Code].
advantages of extending the option of MAiD to individuals with mental illness as their sole underlying medical condition.

Where appropriate, I examine other jurisdictions that offer MAiD. This will help to provide a broader perspective and an understanding of how some of the issues have already been dealt with. Throughout each stage of analysis, I also draw from relevant Canadian court decisions, as well as research studies and commentary papers. Altogether, these will provide for a thorough understanding of the issues at stake. I conclude with an overview of the best courses of action available for MAiD, as guided by the analysis.

I. The History of MAiD Legislation

The discussion of MAiD began in 1992 by Ms. Sue Rodriguez. At the time, Ms. Rodriguez was a 42-year-old terminally ill woman diagnosed with Amyotrophic Lateral Sclerosis (ALS). ALS is an incurable disease that results in a gradual paralysis of all limbs, with the average duration of life being about two to five years from the onset of the disease. Ms. Rodriguez did not desire to live in a state which she considered to be intolerable, and therefore sought the ability to choose when and under which circumstances her life would be terminated.

At the time, section 241 of the Criminal Code prohibited anyone from aiding or abetting someone else to die by suicide. Therefore, individuals who were irremediably ill but unable to end their own lives due to their own physical disability could not seek a physician’s assistance in dying. Instead, they had to either continue suffering until their death came naturally, or take their own life prematurely while still able to do so, often by inhumane means.

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9 See Rodriguez v British Columbia (AG), 76 BCLR (2d) 145 at para 1, [1993] 3 WWR 553 [Rodriguez CA].


11 This was an argument advanced in Carter v Canada (AG), 2015 SCC 5 at para 1 [Carter].
Ms. Rodriguez petitioned that section 241 of the *Criminal Code* should be declared invalid pursuant to subsection 24(1) of the *Charter*. She argued that since section 241 prohibited a terminally ill patient from being helped to die with the assistance of a physician, and because it deprived disabled persons of a benefit and subjected them to a burden, it violated both sections 7 and 15 of the *Charter*. Ms. Rodriguez argued that the prohibition was over-inclusive by not making an exception for those who were terminally ill and mentally competent, but physically unable to end their lives on their own.

Section 7 of the *Charter* guarantees everyone “the right to life, liberty, and security of [their] person”, and to be deprived of such only when “in accordance with the principles of fundamental justice.” Ms. Rodriguez claimed that since her illness rendered her incapable of ending her life on her own, and section 241 of the *Criminal Code* prohibited anyone else from helping her die by suicide, she could not control what happened to her own body while she was living, and therefore her right to liberty and security was violated.

Section 15 of the *Charter* recognizes that every individual is equal before and under the law, and that they have the right to the equal protection and equal benefit of the law without discrimination. Ms. Rodriguez petitioned that, since it is lawful for people to die by non-assisted suicide, to consent to the withdrawal of life support systems or treatments, or to medicate in therapeutic doses to relieve pain, section 241 was discriminatory

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13 Ms. Rodriguez also claimed section 241 of the *Criminal Code* violated sections 12 and 15 of the *Charter*; however, the courts held that these sections were not applicable: see *Rodriguez Sup Ct*, supra note 12 at paras 27–30; *Rodriguez CA*, supra note 9 at para 78.
14 See *Rodriguez v British Columbia (AG)*, [1993] 3 SCR 519 at 590, 107 DLR (4th) 342 [*Rodriguez SCC*].
15 *Charter*, supra note 5, s 7.
16 See *Rodriguez SCC*, supra note 14 at 583.
17 See *Charter*, supra note 5, s 15.
by denying her physician-assisted suicide. The law permitted able-bodied persons to choose to die when they desired, but restricted disabled individuals, who were physically unable to die by non-assisted suicide, from doing so with assistance.

The British Columbia Superior Court ruled against Ms. Rodriguez, stating that the purpose of the Charter is to maintain the sanctity of life. Including the right to suicide under section 7 would therefore be inconsistent with the life, liberty, and security of the person. Ms. Rodriguez appealed to the British Columbia Court of Appeal, and subsequently to the Supreme Court of Canada (SCC), but both levels of court dismissed her case. By a five-to-four majority, the SCC held that although the prohibition in section 241 did violate section 7 by depriving Ms. Rodriguez of autonomy over her person and by causing her physical pain and psychological stress in a manner which infringed the security of her person, it did so in a manner consistent with the principles of fundamental justice. The SCC ruled that creating an exception for disabled individuals would frustrate the legislation’s purpose of protecting the vulnerable. The law was therefore held to not be arbitrary or unfair.

With respect to section 15, the SCC concluded that disabled persons who were unable to end their lives on their own were indeed being discriminated against. However, the infringement was “clearly” saved under section 1 of the Charter. This was based on the premise that a prohibition without any exceptions was the best approach to protecting vulnerable individuals.

After the Court’s ruling in Rodriguez, section 241 of the Criminal Code remained unchanged until the Court’s subsequent decision in Carter.

\[\text{\smaller 18 See Rodriguez Sup Ct, supra note 12 at para 29}\]
\[\text{\smaller 19 See ibid at para 26.}\]
\[\text{\smaller 20 See Rodriguez CA, supra note 9 at paras 12, 174; Rodriguez SCC, supra note 14 at paras 78–84.}\]
\[\text{\smaller 21 See Rodriguez SCC, supra note 14 at 588, 608.}\]
\[\text{\smaller 22 See ibid at 601, 608.}\]
\[\text{\smaller 23 See ibid at 612–13.}\]
\[\text{\smaller 24 See ibid at 613.}\]
\[\text{\smaller 25 Ibid.}\]
in 2015.26 Like Rodriguez, the original plaintiff in Carter, Ms. Gloria Taylor, suffered from ALS.27 By 2010, she required a wheelchair to go more than a short distance, suffered pain from muscle deterioration, and required constant support for daily living tasks. Motivated by the desire to maintain dignity and independence, Ms. Taylor challenged the constitutionality of the assisted suicide prohibition in section 241 of the Criminal Code, together with several related provisions.28 She argued that, to the extent the provisions prohibited “competent, grievously, and irremediably ill adult individuals who voluntarily sought physician-assisted dying on an informed basis from receiving such assistance,”29 they unjustifiably infringed sections 7 and 15 of the Charter.30

In a unanimous decision, the SCC in Carter ruled that section 241 of the Criminal Code violated all three aspects of section 7: the right to life, liberty, and security of the person.31 In summary, the SCC concluded that section 241 might result in some individuals taking their own lives prematurely, while they were still capable of doing so, and before their suffering became intolerable.32 The SCC also held that the section prevented people from making a fundamental personal choice about their lives absent state

26 See Carter, supra note 11 at para 5.

27 See ibid at paras 11–12; Carter v Canada (AG), 2012 BCSC 886 at paras 44, 47, 50, 57–58 [Carter Sup Ct] (Ms. Taylor was joined in her claim by Lee Carter and Hollis Johnson, who had assisted Kathleen Carter with obtaining MAiD by taking her to Switzerland to use the services there. Kathleen Carter had suffered from spinal stenosis, a condition involving progressive compression of the spinal cord).

28 See Carter, supra note 11 at paras 11, 30 (ALS patients gradually lose the ability to use their hands and feet, then the ability to walk, chew, swallow, speak and, eventually, breathe; Ms. Taylor “[did] not want to die slowly, piece by piece” at para 11).

29 Carter Sup Ct, supra note 27 at paras 22, 25.

30 Carter Sup Ct, supra note 27 at paras 22, 25.

31 The plaintiffs also claimed section 241 of the Code violated section 15 of the Charter; however, upon concluding that section 7 was violated, the SCC deemed it unnecessary to consider section 15. It therefore remains unaddressed as to whether section 15 was violated: see Carter, supra note 11 at paras 56, 93.

32 See ibid at paras 57, 64.
interference. Lastly, the violation was not justified under section 1 of the Charter.

Although the SCC conceded that the law had a pressing and substantial objective, and that a broad prohibition was a rational method of decreasing inherent risks, it maintained that it is feasible for physicians to reliably assess patient competence and voluntariness, and that coercion, undue influence, and ambivalence could all be reliably assessed as part of that process. The Court thereby held that vulnerability could be assessed on a case-by-case basis, thus rendering a blanket prohibition unnecessary. Section 241 of the Criminal Code was thus declared void insofar as it prohibited physician-assisted death for competent and consenting adult persons who had a grievous and irremediable medical condition with intolerable suffering.

The federal government enacted Bill C-14, which was given royal assent on 17 June 2016. Bill C-14 made it legal under subsection 241(2) of the Criminal Code for a medical or nurse practitioner to provide a person with MAiD. The Bill further enacted section 241.2 of the Criminal Code to outline the eligibility requirements for one to receive MAiD, which reads as follows:

241.2 (1) A person may receive medical assistance in dying only if they meet all of the following criteria:

a) they are eligible - or, but for any applicable minimum period of residence or waiting period, would be eligible - for health services funded by a government in Canada;

See ibid.

See ibid at para 123.

See ibid at paras 96, 100, 106, 120–121 (it was also rejected that an adoption of a regulatory regime would initiate a descent down a “slippery slope” into condoning murder at para 121).

See ibid at para 115.

See ibid at paras 126–127.

See Bill C-14, supra note 1.

See ibid, s 241(2); Criminal Code, supra note 8, s 241(2).
b) they are at least 18 years of age and capable of making decisions with respect to their health;

c) they have a grievous and irremediable medical condition;

d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and

e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

(2) A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

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.  

Notably, Carter considered the case of competent adults who (1) clearly consent to the termination of their life and (2) have a grievous and irremediable medical condition. Carter defined “grievous and irremediable” as a condition which “causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.” The SCC made it clear that they were not going to make any pronouncement on other situa-

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40 Criminal Code, supra note 8, ss 241.2(1)–(2).
41 See Carter, supra note 11 at para 127.
42 Ibid.
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Due to the restrictions in the eligibility requirements, the option to request MAiD remains limited for individuals with mental illness. Only those who meet the eligibility criteria and who have the capacity to consent will be granted access to MAiD. As required by clause 9.1 of Bill C-14, the Council of Canadian Academies conducted an independent review of the issues relating to requests by individuals with a mental illness as their sole underlying medical condition. Upon releasing the report in December 2018, the Council confirmed that very few individuals with mental illness as their sole underlying medical condition are likely to qualify for MAiD under the current eligibility criteria.

On a review of other jurisdictions, the only other locations that have legalized a form of MAiD are eleven American states (Washington, Oregon, Colorado, Hawaii, Vermont, Montana, Washington, the District of Columbia, New Jersey, Maine, and California), one Australian state (Victoria), Colombia, Belgium, the Netherlands, Switzerland, and Luxembourg. Interestingly, the European countries have dispensed with the requirement that natural death be reasonably foreseeable.

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43 Carter therefore offered a guide for the legislature, who in turn opted to narrow the definition in Carter by requiring the “grievous and irremediable” component to include that the individual’s natural death be reasonably foreseeable.44

44 See Carter, supra note 1, s 241.2(2).

45 See CCA Report, supra note 4; Bill C-14, supra note 1, s 9.1.

46 See CCA Report, supra note 4 at 63, 150, 192. See also Jeffrey Kirby, “Medical Assistance in Dying for Suffering Arising from Mental Health Disorders: Could Augmented Safeguards Enhance its Ethical Acceptability?” (2017) 10 J Ethics Mental Health 1 at 2.


48 See HOC Debate, supra note 2 at 3841; Termination of Life on Request and Assisted Suicide (Review Procedure) Act, Netherlands 2002; The Belgian Act on Euthanasia, Belgium 2002, c 2, art 3 [Belgian Act] (both the physical or
mental illness as their sole underlying medical condition may be deemed eligible to receive MAiD in these countries.

The remainder of this article examines the issues surrounding requests for MAiD by individuals with mental illness as their sole underlying medical condition.

II. A CLOSER LOOK AT THE INTERSECTION OF MAiD AND THE LAW

A. Mental vs. physical illnesses

It is common for people to draw strong distinctions between mental and physical illnesses. This perspective is often grounded in the assumption that since mental illness is not physically visible, it is an ailment of the mind rather than the body. This has partially led to mental illness having become highly stigmatized, and often believed to not be a “real illness”. In reality, mental and physical illnesses are closely linked in numerous ways.

Mental and behavioural disorders constitute one of the 22 different classifications of health problems recognized by the World Health Organization. Several of these categories, such as “infectious or parasitic diseases”, are based on etiology. Others, such as “diseases of the digestive system”, are based on the primary organ system that is affected. “Mental and behavioural disorders” constitute a heterogeneous category determined by the medical specialty that is primarily responsible for the treatment. Although mental illness and physical illness are both classified and recognized by the World Health Organization, they are diagnosed and treated differently.

Linking mental and physical illnesses is the fact that the body and the brain are interconnected, thus it is impossible to fully separate the “physical” from the “mental”. When people develop an illness, both the mind and body play a role. Although researchers are still investigating the exact caus-
es of mental illness, they generally accept that a combination of genetic, biological, psychological, and environmental factors are at play.\textsuperscript{51} Physical illnesses can be the result of one or more of these same factors.\textsuperscript{52} With mental illness, however, we are a long way from understanding the interplay among the factors.\textsuperscript{53}

Not only do mental and physical illnesses derive from similar causes, but they also frequently interact with each other. Individuals suffering from mental illness are at a higher risk of developing a wide range of chronic physical conditions than the general population.\textsuperscript{54} Likewise, people suffering from chronic physical conditions develop mental illness, such as depression and anxiety, at twice the rate of the general population.\textsuperscript{55}

The main differences between mental and physical illnesses emerge at the diagnosis stage. Physical illnesses can often be diagnosed via physical symptoms, blood tests, x-rays, or other objective methods.\textsuperscript{56} In contrast, the diagnosis of a mental illness is a more subjective, symptom-based endeavour conducted by experts in the field, often involving several interviews and rating scales. To warrant a mental illness diagnosis, the symptoms must satisfy the diagnostic criteria on a pre-set checklist.\textsuperscript{57} Dr. Thomas Insel, former Director of the National Institute of Mental Health, believes that the diagnosis and treatment of mental illness are today where physical illnesses were 100 years ago.\textsuperscript{58}

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\item \textsuperscript{51} See \textit{ibid}. See also Kirsten Weir, “The Roots of Mental Illness” (2012) 43:6 Monitor Psychology 30 at 33.
\item \textsuperscript{52} See Kendell, \textit{supra} note 48 at 491.
\item \textsuperscript{53} See Weir, \textit{supra} note 50 at 33.
\item \textsuperscript{54} See “The Relationship between Mental Health, Mental Illness and Chronic Physical Conditions” (2017), online: \textit{Canadian Mental Health Association} <www.ontario.cmha.ca/documents/the-relationship-between-mental-health-mental-illness-and-chronic-physical-conditions/> [perma.cc/3BL5-F9XL]. See also Alec Yarascavitch, “Assisted Dying for Mental Disorders: Why Canada’s Legal Approach Raises Serious Concerns” 10 JEMH 1 at 5–6.
\item \textsuperscript{55} See \textit{ibid}.
\item \textsuperscript{56} See Weir, \textit{supra} note 51 at 30.
\item \textsuperscript{57} See DSM, \textit{supra} note 6 at Section II; CCA Report, \textit{supra} note 4 at 37–38.
\item \textsuperscript{58} See Weir, \textit{supra} note 51 at 30.
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Another key difference between mental and physical illnesses is the degree of predictability. Mental illness can affect each individual very differently, often resulting in individuals sharing the same diagnosis despite presenting different symptom profiles.\(^{59}\) Moreover, the course of mental illness can range anywhere from being stable, relapsing and remitting, progressive, or entirely unpredictable.\(^{60}\) Due to the unpredictable nature of many mental illness conditions, it is often difficult to predict a priori which patients will recover.\(^{61}\) Physical illnesses, on the other hand, can typically be linked to specific pathologies, which may make it easier to predict the course of the illnesses. Adding to the unpredictability of mental illness is the fact that many chronic mental illness conditions are influenced by the quality of care and social support which the individual receives.\(^{62}\) However, this is also true of physical illnesses.

Altogether, while there are many similarities between mental and physical illnesses, more research must be completed on mental illness for it to be understood to the same extent as physical illness. The need for research supports the government’s initiative of conducting an independent review on the issues relating to requests for MAiD by individuals with mental illness as their sole underlying medical condition. The similarities of the illnesses are also suggestive that the eligibility criteria should be revised so that individuals with mental illness are granted the same rights as those with a physical illness. These criteria are discussed in the next part.

B. Eligibility criteria

The Parliament of Canada established very specific eligibility criteria for MAiD.\(^{63}\) These criteria represent the Parliament’s current perspective on what constitute reasonable and acceptable circumstances for accessing


\(^{60}\) See CCA Report, *supra* note 4 at 47, 151. See also Yarascavitch, *supra* note 54 at 16–17, 26.

\(^{61}\) See CCA Report, *supra* note 4 at 34, 38–39 (“[t]he heterogeneous nature of the diagnostic categories for mental disorders makes it difficult to know which specific patient will benefit from which of the available treatments” at 39).

\(^{62}\) See *ibid* at 27–28.

\(^{63}\) See *Criminal Code*, *supra* note 8, s 241.2(1).
MAiD. To determine whether individuals with mental illness should have the option of MAiD available to them, I will address whether they can meet the criteria in the first place. This will assist with identifying which eligibility criteria under the current legislation present restrictions and challenges for individuals with mental illness. For the purposes of this article, however, I will only address the potentially contentious criteria, which are paragraphs 241.2(1)(c) and (e) of the Criminal Code. The criteria listed under paragraphs 241.2(1)(a), (b), and (d) will therefore not be analyzed.

1. Serious and incurable illness

The first aspect of a grievous and irremediable medical condition is to have a serious and incurable illness, disease, or disability. The seriousness and incurability of an illness will be assessed as two distinct requirements.

The National Institute of Mental Health defines a serious mental illness as “a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.” While it is possible for any mental illness condition to become classified as “serious” if it causes significant functional impairment, there are numerous types of mental illness that have been recognized as “serious”, including schizophrenia, bipolar disorders, major depressive disorders, and post-traumatic stress disorders.

At the diagnostic stage, the DSM requires clinicians to rate the “severity” of each patient’s mental illness. Clinicians do so by grading patients on a scale from “mild” to “extreme” according to an assessment of various

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64 See CCA Report, supra note 4 at 151.
65 See Criminal Code, supra note 8, s 241.2(1).
66 See ibid, s 241.2(2)(a).
69 See DSM, supra note 6 at 21.
Such factors include symptom salience, perceived distress with regard to symptoms, disability resulting from symptoms, and clinician judgement. The severity of a serious mental illness condition therefore varies along a spectrum. While one may be diagnosed with a “serious” mental illness condition, they may not necessarily suffer from a “severe” version of it. A full psychiatric assessment must be conducted of each patient to assess whether they meet the criteria of “severe”.

Altogether, individuals diagnosed with a mental illness condition that has been recognized as “serious”, or as otherwise causing significant functional impairment, will satisfy this MAiD criterion. In addition, the severity measure could be used to indicate how severe the serious mental illness is. More “severe” illnesses should therefore have less trouble satisfying the criterion than more “mild” ones.

As for curability, there are several reasons why an illness may be declared incurable. In the Criminal Code, “incurable” does not necessarily mean that an illness is not capable of being cured “by any means”. Rather, the Minister of Health at the time, Dr. Jane Philpott, explained that an illness is deemed incurable when there is either no known cure, the patient has a contraindication to the available treatment(s), the treatment is not accessible or is inappropriate in the circumstances, or there is no informed consent. I discuss each of these possibilities in the remainder of this Sub-Part, with the exception of no informed consent, which is discussed in Sub-Part 5.

No Known Cure

Psychiatrists have argued that mental illness can be considered incurable since the severe suffering associated with some conditions cannot always be alleviated. Recent reports on MAiD in Canada for people with mental illness also support the proposition that they can be incurable and that palliative psychiatry is the only remaining option in such cases. Palliative psychiatry shifts the focus from treating mental illness to promoting

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70 See *ibid* at 22.

71 See Senate Debate 1, *supra* note 2 at 766.

72 See Justine Dembo, “Mental Illness and Medical Assistance In Dying (MAiD) Debate” (Speaker panel delivered at the HealthAchieve Conference, Toronto, 6 November 2017) [unpublished] [Dembo, “MAiD Debate”].
quality of life.\textsuperscript{73} While these claims may be influenced by the proponents’ potential bias for MAiD from working in the industry, they have been supported by multiple studies.

For example, a study conducted by Dr. Almut Zeeck et al. provided psychotherapy treatment to 604 participants who suffered from depression.\textsuperscript{74} Approximately half of the participants had severe depression, about 66\% of the participants experienced an average of three recurrent episodes of major depressive disorder, and most of the participants had already undergone previous treatments (e.g. psychosomatic, psychotherapeutic, psychiatric).\textsuperscript{75} All participants were capable of giving informed consent. Upon a three-month follow-up after discharge from the psychotherapy treatment, 27.4\% of the participants showed full remission, while approximately 60\% still exhibited at least 50\% of their symptoms. In particular, 29\% of them indicated no response to the treatment.\textsuperscript{76} Other studies have shown very similar rates when treating outpatients with nonpsychotic major depressive disorder.\textsuperscript{77} Indeed,

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\textsuperscript{73} Despite all efforts, some patients develop severe and persistent mental illness. In response, palliative psychiatry has emerged in recent years, with the aim of promoting quality of life, person-centeredness, and autonomy, rather than achieving a cure or treatment plan. Palliative care can also include psychosocial and spiritual support for both the patient and the family. See Manuel Traschel et al, “Palliative Psychiatry for Severe and Persistent Mental Illness” (2016) 3:3 Lancet Psychiatry 200; Jocelyn Downie & Justine Dembo, “Medical Assistance in Dying and Mental Illness under the New Canadian Law” (2016) JEMH 1 at 4–5.

\textsuperscript{74} See Almut Zeeck et al, “Symptom Course in Inpatient and Day Clinic Treatment of Depression: Results from the INDDEP-Study” (2015) 187 J Affect Disord 35 at 37 (treatment was provided five days a week for six to twelve weeks). See also Udo Schuklenk & Suzanne van de Vathorst, “Treatment-resistant Major Depressive Disorder and Assisted Dying” (2015) 41 J Med Eths 577 at 580 (patients diagnosed with major depression are typically not deemed “treatment-resistant” unless they have undergone extensive long-term professional psychiatric care, and experienced a failure of multiple therapeutic approaches, such as a ‘significant’ number of antidepressants, psychotherapy, and electroconvulsive therapy).

\textsuperscript{75} See Almut Zeeck et al, supra note 74 at 42.

\textsuperscript{76} See ibid.

\textsuperscript{77} See Downie & Dembo, supra note 72 at 4 (only 50\% of inpatients with severe depression responded to treatment and these patients had previously failed an average of eight antidepressant medications from four classes and at least two
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Dr. John Rush et al. noted that 33% of participants did not respond to treatment.\footnote{78} Furthermore, one year after treatment, 71% of the patients who had responded to treatment later relapsed.\footnote{79}

There are, however, studies that show more promising results. Dr. Esme Fuller-Thomson et al. analyzed the public use data set of the 2012 Canadian Community Health Survey-Mental Health and found that two in five Canadians with a history of depression eventually reached complete mental health.\footnote{80} Further, those who had experienced a depressive episode for two or more years were found to be equally as likely to achieve complete mental health as those whose longest depression lasted only one month.\footnote{81} Another study used the Canadian National Population Health Survey to assess 1,128 adults with depression over the course of 12 years.\footnote{82} The study revealed that approximately 77% of participants were no longer depressed after two years and 94% of them achieved remission after 12 years.\footnote{83} Although these studies offer hope that depression can be cured, it is notable that in the former study there were still 60% of Canadians with depression who had not

courses of electroconvulsive therapy). See also Stephan Köhler et al, “Characteristics and Differences in Treatment Outcome of Inpatients with Chronic vs. Episodic Major Depressive Disorders” (2014) 173 J Affect Disord 126 at 131–133 (pharmacological interventions had no significant influence on the treatment outcome of inpatients with chronic major depressive disorder).

\footnote{78} See John Rush et al, “Acute and Longer-Term Outcomes in Depressed Outpatients Requiring One or Several Treatment Steps: A STAR*D Report” (2006) 163:11 Am J Psychiatry 1905 at 1910–17 (participants who had not been previously treated for their current depressive episode had a 42.7% remission rate, compared to a 35.6% remission rate for those who had been treated previously).

\footnote{79} See ibid at 1912.


\footnote{81} See ibid at 118.

\footnote{82} See Esme Fuller-Thomson et al, “Bouncing Back: Remission from Depression in a 12-year Panel Study of a Representative Canadian Community Sample” (2014) 49 Soc Psychiatry Psychiatr Epidemiol 903 at 905 [Fuller-Thomson et al, “Bouncing Back”] (participants were screened positive for depression if they had a probability of 90% or greater for a major depressive episode over a period of at least 2 weeks in the last year).

\footnote{83} See ibid at 906.
achieved complete mental health, and in the latter study there was still six percent (67 individuals) who never remitted even after 12 years.

In addition to the studies conducted on patients with depression, many other mental illness conditions have been shown to be incurable or resistant to sufficient symptom relief.\textsuperscript{84} Approximately 41\% of patients with affective disorders cease treatment without any significant changes in their symptoms;\textsuperscript{85} only 50\% of patients with obsessive-compulsive disorder who have not responded to first, second, and third line treatments benefit from an invasive treatment;\textsuperscript{86} and 20\% of patients with anorexia remain severely unwell.\textsuperscript{87} Overall, it is evident that although psychiatric research is advancing, there remain significant proportions of mentally ill patients who do not respond to the psychiatric care that is available to them.

The incurable nature of mental illness has also been accepted by Canadian courts. In \textit{Canada (AG) \textsc{v} \textsc{F(E)}}\textsuperscript{88}, the Alberta Court of Appeal recognized that the patient’s severe conversion disorder was incurable. A physician involved in this case deposed that:

\begin{quote}
there are no further treatment options for the applicant that would offer any hope of improvement in her condition, or meaningful reductions in her symptoms. … Given the length of time the symptoms have been present, the treatment history
\end{quote}

\textsuperscript{84} See CCA Report, \textit{supra} note 4 at 39–40.

\textsuperscript{85} See Laurence Reuter et al, “Pretreatment and Process Predictors of Nonresponse at Different Stages of Inpatient Psychotherapy” (2015) 26:4 Psychother Res 410 at 412, 419 (546 inpatients were provided with psychotherapeutic treatment; affective disorders include somatoform disorders, eating disorders, and personality disorders at 415).


\textsuperscript{88} 2016 ABCA 155 at paras 65–66. This case dealt with a request for the plaintiff to avail herself of the constitutional exemption granted in \textit{Carter, \textit{supra}} note 11, whereby she would be permitted to proceed with MAiD prior to the enactment of Bill C-14. This case therefore does not comment directly on the current legislative scheme but is rather an example of a patient who requested MAiD on the basis of mental illness.
and her lack of response, I considered her condition to be ir-remediable.\footnote{Ibid at para 63.}

A strong critique of this case is that the physician who made this statement, despite having 40 years of experience practising medicine, did not specialize in mental health. Moreover, the only psychiatrist involved in the assessments never examined the patient, but instead merely reviewed her file.\footnote{See Trevor Hurwitz, “Euthanasia in Mental Illness: A Four Part Series Part I: The Case of EF” (2017) 10 JEMH 1 at 8.} Further concerns were raised about the sufficiency of the psychiatric evidence before the trial judge; however, the degree of knowledge of this evidence is limited due to the implementation of a publication ban.\footnote{See ibid at 3.}

Notwithstanding these critiques, \textit{Canada (AG) v F(E)} still offers some evidence, albeit weak, that the judiciary has recognized that mental illness may be capable of being incurable. Even more convincing is the following statement offered by the motions judge:

\begin{quote}
[N]one of the multitude of traditional or non-traditional treatments, therapies, or trials that the applicant has undergone for over nine years since the onset of her medical condition has remedied the applicant’s medical condition or made it right. The evidence clearly establishes that the physical symptoms suffered by the applicant as a result of her medical condition deprive her of any quality of life. The fact that the applicant’s medical condition is diagnosed using the DSM-5 or the fact that it has a psychiatric component cannot be permitted to overshadow the real horrific physical symptoms that the applicant is most definitely experiencing on a continual and daily basis. … I am completely satisfied the applicant’s medical condition is both grievous and irremediable.\footnote{Canada (AG) v F(E), supra note 88 at paras 65–66 [emphasis added] (no error was found in the motions judge having reached these conclusions).}
\end{quote}

Unfortunately, \textit{Canada (AG) v F(E)} is the only known case on MAiD for mental illness in Canada. However, this decision combined with the findings from \textit{Carter} suggests that the legislature should take these recogni-
tions regarding incurability into consideration when legislating on the matter of mental illness and MAiD.

There are others who argue, however, that mental illness can be temporary and manageable. In discussing the concerns regarding the current MAiD legislation, Dr. Alec Yarascavitch explained that bi-polar disorder – a life-long mental illness – can be managed with medication. Further, Dr. Abebaw Fekadu et al. found that with intensive, specialized treatment, most individuals with treatment-resistant depression can achieve remission. Studies have also found that when chronically ill patients are treated over a long period of time and are provided the standard of care, they exhibit significant rates of improvement. These findings, however, do not account for the unique circumstances of every patient, or the various mental illness conditions in existence.

Together, although there are multiple studies suggesting that mental illness can be considered incurable, there is little consensus about what constitutes sufficient symptom relief, or on the proper number or type of interventions that should be tried before one is declared incurable. Another key consideration is that remission is merely a clinical decrease in the number and severity of symptoms and thereby not actually a “cure”. Considering many studies indicate that mental illness is capable of “remission”, this sug-

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93 See Mark Henick, “Mental Illness and Medical Assistance In Dying (MAiD) Debate” (Speaker panel delivered at the HealthAchieve Conference, Toronto, 6 November 2017) [unpublished]; Senate Debate 2, supra note 2 at 1234; Public Health Agency of Canada, The Human Face of Mental Health and Mental Illness in Canada 2006 (Ottawa: Public Works and Government Services, 2006) at 47 [Public Health Agency of Canada].

94 See Yarascavitch, supra note 54 at 17. See also Fuller-Thomson et al, “Bouncing Back”, supra note 82 at 906.

95 See generally Abebaw Fekadu et al, “Prediction of Longer-Term Outcome of Treatment-Resistant Depression in Tertiary Care” (2012) 201:5 Br J Psychiatry 369.


97 See CCA Report, supra note 4 at 40.

gests that the mentally ill are, in fact, suffering from an incurable illness, despite having experienced symptom relief. Complicating this is the fact that treatment resistance is a retrospective concept and may be influenced by the individual’s environment. Therefore, treatment resistance does not actually suggest that a person has no hope of improvement, but merely that their condition has not yet improved.  

Contraindication

As stated, the definition of “incurable” accounts for the patient’s specific position. In addition to failed treatments, there are also cases in which mental illness is deemed incurable because the available treatments are adverse to the individual’s interests and could cause additional harm. This is often the case when the available treatments are very invasive, such as electroconvulsive therapy, deep brain stimulation, and psychosurgery, or their side effects are severe.

The individual patient’s perspective was considered in Fleming v Reid, which noted the potential side effects of antipsychotic medication. In that case, the medications prescribed to the appellant were neuroleptics. Possible side effects of neuroleptics include muscle spasms, protrusion of the tongue, physical immobility, blurred vision, and sudden death. The appellant maintained that he did not wish to risk these side effects, thereby marking his illness as incurable by way of contraindication.

More recently, a study for patients with schizophrenia showed rates of treatment discontinuation ranging from 64–82%. This outcome suggests that the effectiveness of many antipsychotic drugs is limited by the intoler-
ability of their side effects. In this same vein, other research indicates that as mental illness conditions progress and become more serious, the available treatments are typically less tolerable, and a contraindication is therefore more likely to be declared.  

**Inappropriate**

The treatment available to a patient might not be appropriate in specific circumstances. The term “appropriate” is typically used by policymakers, despite its meaning being unclear and subjective.  

In an effort to identify what patients and their relatives perceive as inappropriate care, Dr. Eva Elizabeth Bolt et al. surveyed 592 individuals. One of the most commonly reported factors was overtreatment, such as receiving overly aggressive treatment near the end of life or continued treatment despite no change in health. As discussed previously, it is common for a mentally ill patient to not respond to treatment, thus continuing treatment would be inappropriate. In such situations, where there is no appropriate treatment remaining, the patient’s illness is considered incurable.

Altogether, an individual’s illness can be declared incurable for many reasons. Whether it be due to a lack of known cures or informed consent, contraindication, or the inappropriateness of treatments, there are many forms of mental illness that satisfy the MAiD criterion of incurable illness.

### 2. Irreversible decline in capability

The second potentially contentious criterion of the MAiD requirements is that the individual must be in an “advanced state of irreversible decline
The discussion of this criterion will also be broken down according to its two main components: irreversible decline and capability.

“Irreversible decline” is not defined in the legislation and must therefore be interpreted. In place of this criterion, other jurisdictions with MAiD legislation have “terminal illness” as a criterion, which they define as an irreversible condition that will produce death within six months. If this perspective were used to interpret the Criminal Code, there could be some overlap with the “reasonably foreseeable natural death” criterion; although a reasonably foreseeable death will not always be considered terminal, all terminal illnesses result in a reasonably foreseeable death. It is likely that the legislature intended for each criterion to be predominantly mutually exclusive, thus “irreversible decline” should not be interpreted as being analogous to a terminal illness.

As noted in the CCA Report, it is also unclear whether the decline in capability is to occur over a period of time, or if it is to be more sudden. Mental illness impacts every aspect of an individual’s life, including personal and family relationships, education, and employment. Individuals suffering from severe mental illness typically score lower than the general population on measures of physical functioning. Indeed, mental illness has been declared as a leading cause of disability in Canada. This is in part

109 See Criminal Code, supra note 8, s 241.2(2)(b).
110 See HOC Debate, supra note 2 at 3840–41.
111 See Criminal Code, supra note 8, s 241.2(2)(d) (note that having a terminal illness is not a requirement to request MAiD in Canada).
112 See CCA Report, supra note 4 at 74, 155.
113 See Public Health Agency of Canada, supra note 92 at 38. See also Downie & Dembo, supra note 73 at 5; Allen Frances, “Having a Severe Mental Illness Means Dying Young” (29 December 2014), online (blog): Psychology Today <www.psychologytoday.com/blog/dsm5-in-distress/201412/having-severe-mental-illness-means-dying-young> [perma.cc/8C9Y-L5MK]; CCA Report, supra note 4 at 44–45.
114 See CCA Report, supra note 4 at 74.
due to the severity of certain mental illness conditions, which can result in some individuals ceasing to eat, drink, or attend to hygiene or other forms of self-care and preventative healthcare. Further, they often become increasingly isolated and unable to work, as they become severely exhausted and find it difficult to engage in social relationships. As the illness worsens, the risk of homelessness is significant, and access to education and job opportunities tend to diminish. All of these impacts further exacerbate the illness, thereby creating an irreversible cycle.

There are also more specific forms of irreversible decline for different illnesses. For example, individuals suffering from bipolar disorder exhibit a high risk of harm resulting from risky or dangerous behaviours. Moreover, eating disorders can lead to irreversible consequences of severe malnutrition, including organ failure, cognitive decline, and premature osteoporosis.

According to a study conducted in 2002, the longer someone has suffered from a mental illness condition, the greater the degree of irreversible disability. This study found that mental illness accounts for 9.4% of the disability-adjusted life years worldwide. This is comparable to 9.9% for cardiovascular disease and 5.1% for cancer. There is therefore evidence that mental illness can cause an irreversible decline in capability of physical functions.

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116 See Public Health Agency of Canada, supra note 93 at 32, 73. See also Downie & Dembo, supra note 73 at 5; Frances, supra note 113.

117 See Public Health Agency of Canada, supra note 93 at 6, 12, 17. See also Downie & Dembo, supra note 73 at 5.

118 See Downie & Dembo, supra note 73 at 5. See also CCA Report, supra note 4 at 44–45.

119 See Downie & Dembo, supra note 73 at 5.

120 See CCA Report, supra note 4 at 74.

121 See Public Health Agency of Canada, supra note 93 at 38.

122 A “disability-adjusted life year” is equivalent to one lost year of “healthy” life. When tallied across a population, it is used to compare the gap between the overall health and what it would be in an ideal situation free of disease and disability.
The “capability” aspect is not defined in terms of “capability to do what?” The lack of specificity suggests the intention of the legislature was to adopt a liberal interpretation and assess the impact of an illness on an individual’s general abilities. Individuals are generally capable of a wide range of functions, thus a broad interpretation allows for one’s “capability” to not be restricted to physical functions, but to also include declines in cognitive capabilities. The *Oxford English Dictionary* defines “capability” as the “power or ability in general, whether physical or mental.” The inclusion of an irreversible decline of mental capabilities would evidently capture a significant number of individuals with mental illness.

Capturing more people, however, will not always result in greater access to MAiD. While there are many forms of cognitive dysfunction that do not negatively affect one’s eligibility for MAiD, there are other forms that could affect one’s decision-making capacity and therefore impact eligibility. For example, if the mental illness condition were to give rise to an inability to give valid informed consent, then despite satisfying the “irreversible decline in capability” criterion, the individual would be ineligible for MAiD based on the requirement to have capacity. The capacity requirement will be discussed in greater detail in Sub-Part 5 of this article.

### 3. Enduring physical or psychological suffering

Third, the *Criminal Code* requires that the illness or state of decline cause the individual enduring physical or psychological suffering that is intolerable to them. This wording suggests a subjective analysis. It favours access to MAiD, because unlike with physical illnesses, there is no evidence-based or diagnostic tool to operationalize “intolerable suffering”.

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126 See *Criminal Code, supra* note 8, s 241.2(2)(c).
Those in support of broadening access to MAiD for mental illness claim that all suffering is equal and that the suffering should therefore not depend on whether the underlying cause is physical or mental.127 This argument was also raised in Canada (AG) v F(E), where the Alberta Court of Appeal stated that the “cruelty” in the situation prevails regardless of the form that the underlying illness takes.128 Many organizations, researchers, and the courts agree that mental illness can cause intolerable suffering.129

When comparing the enduring suffering of mental illness against physical illnesses, the Global Burden of Disease Study reports that the level of disability caused by major depression is akin to that caused by blindness or paraplegia, and that the level of disability caused by active psychosis, such as in schizophrenia, results in almost the same level of disability as quadriplegia.130 Further, five of the ten leading causes of disability worldwide are mental illness-related, and notably, unipolar major depression ranks as number one.131 That said, some individuals who experience high levels of disability may not be “suffering” from mental illness, and others who experience symptoms of mental illness, including suffering, may still function well.132 It must be recognized that the form of enduring suffering, either physical or mental, greatly differs for each individual and each type of illness. The Global Burden of Disease Study thereby highlights the magnitude of the impact mental illness can have on different individuals.

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127 See Downie & Dembo, supra note 73 at 3. See also Dembo, “MAiD Debate”, supra note 72.

128 See Canada (AG) v F(E), supra note 88 at paras 7, 37.

129 See ibid at para 37; Statistics Canada, Suicide Rates: An Overview, by Tanya Navaneelan, Catalogue No 82-624-X (Ottawa: Statistics Canada, 2009), online: <www.statcan.gc.ca/pub/82-624-x/2012001/article/11696-eng.htm> [perma.cc/P47A-8RG2] [Statistics Canada, Suicide Rates].


131 See ibid at 21 (the leading conditions included unipolar depression, alcohol use, bipolar affective disorder, schizophrenia, and obsessive-compulsive disorder; unipolar depression was responsible for more than 1 in every 10 years of life lived with a disability worldwide).

132 See CCA Report, supra note 4 at 77.
Poor mental health has also been recognized as the strongest risk factor for suicide, and thus as a significant public health issue in Canada.\textsuperscript{133} Up to 90\% of people who die by suicide likely had mental illness, with depression, personality disorders, and schizophrenia representing the most common diagnoses.\textsuperscript{134} These statistics suggest that the individuals subjectively considered themselves to be enduring intolerable suffering, and therefore would have satisfied this MAiD criterion.

4. Foreseeable death

The final criterion for a “grievous and irremediable” condition is that the individual’s natural death is reasonably foreseeable.\textsuperscript{135} When defending the legislation, Honourable Jody Wilson-Raybould, the then Minister of Justice and Attorney General of Canada, stated that this criterion was intentionally broad to allow medical practitioners to use their expertise and deem what they felt was reasonably foreseeable in the circumstances.\textsuperscript{136} She added that this standard would be determined on a case-by-case basis.

In \textit{AB v Canada (AG)}\textsuperscript{137}, the court provided additional clarification on the parameters of this broad criterion. Justice Perell held that the use of the word “natural” denotes that the foreseeability of the death must be associated with natural causes due to the functioning or malfunctioning of the human body.\textsuperscript{138} The language further denotes that the death does not have to be a result of a terminal illness. Rather, the foreseeability of the death shall have regard to all medical circumstances of the individual.\textsuperscript{139} The fact

\begin{footnotesize}
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\item[133] See \textit{ibid} at 42.
\item[134] See \textit{ibid} (these diagnoses were determined by a retrospective psychological autopsy).
\item[135] See \textit{Criminal Code, supra} note 8, s 241.2(2)(d).
\item[136] See Bill C-14, \textit{An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)}, 2nd reading, \textit{House of Commons Debates}, 42nd Parl, 1st Sess, No 45 (22 April 2016) at 2583.
\item[137] 2017 ONSC 3759 at para 81.
\item[138] See \textit{ibid} at para 81.
\item[139] See \textit{ibid} at paras 37, 81–82.
\end{enumerate}
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that an illness need not be terminal suggests that patients are not required to predict a specific time frame within which their death is thought to occur.

Due to the broad impact that mental illness has on one’s health, individuals with mental illness are much more likely to die prematurely than the general population.\textsuperscript{140} In fact, it has been estimated that mental illness, depending on the type and severity, can shorten lives by approximately 20 years.\textsuperscript{141} The years lost due to mental illness can be almost double that of all cancers, heart diseases, diabetes, and infectious diseases.\textsuperscript{142} With the exception of death by suicide, the causes of death are similar to those of the general population.\textsuperscript{143} Indeed, the causes of death include natural death, as the severely mentally ill often disregard preventative health measures and self-care.\textsuperscript{144}

While these statistics are severe, they are often the result of multiple factors resulting from the presence of the mental illness.\textsuperscript{145} Of concern is that one such factor impacting the foreseeable death criterion could also be a result of inadequate provision of health care,\textsuperscript{146} which stems from the societ-

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\item[\textsuperscript{140}] See Frances, \textit{supra} note 113; CAMH, \textit{supra} note 115; Jennifer Chandler & Colleen Flood, \textit{Law and Mind: Mental Health Law and Policy in Canada} (Toronto: LexisNexis Canada, 2016) at 1.
\item[\textsuperscript{141}] See Frances, \textit{supra} note 113; CAMH, \textit{supra} note 115; World Health Organization, \textit{Information Sheet: Premature Death Among People with Severe Mental Disorders} (2014), online (pdf): <www.who.int/mental_health/management/info_sheet.pdf> [perma.cc/3GSC-PJF3].
\item[\textsuperscript{142}] See Frances, \textit{supra} note 113; CAMH, \textit{supra} note 115; Murray & Lopez, \textit{supra} note 130 at 25.
\item[\textsuperscript{143}] See Frances, \textit{supra} note 113 (although mental illness is a significant risk factor for suicide, this is not relevant to the “reasonably foreseeable death” criterion since the legislation specifically requires that the person’s \textit{natural} death be reasonably foreseeable).
\item[\textsuperscript{144}] See Frances, \textit{supra} note 113. See also Public Health Agency of Canada, \textit{supra} note 93 at 42; Downie & Dembo, \textit{supra} note 72 at 5–6.
\item[\textsuperscript{145}] Many of these factors were noted above under the “Irreversible Decline in Capability” Sub-Part and include a lack of preventative health measures and self-care, as well as a greater likelihood of isolation, homelessness, and engagement in risky behaviours.
\item[\textsuperscript{146}] This includes at the preventative, secondary, or tertiary levels of care.
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nal stigma that surrounds mental illness. A study conducted by Dr. Linda Diem Tran and Dr. Ninez A Ponce found that only 51% of approximately 2.2 million adults with mental health needs in California reported seeing a health professional for their mental health and, within this subset, only 23% received minimally adequate treatment. Among those whose needs remained unmet, nearly half reported stigma as the cause. This included both self-stigma, whereby the individual did not feel comfortable seeking support, and public-stigma, whereby the individual feared that the general population and care providers would react in a way that increased potential for prejudice and discriminatory actions.

This raises a problematic issue in that mental illness may result in a “foreseeable death”, but part of this may be due to patients having received inadequate health care simply because they had a mental illness. In other words, while the shortened life span of individuals with mental illness bolsters an argument to extend access to MAiD to them, it is simultaneously problematic if the shortened lifespan is in part due to the inadequate care resulting from societal stigma rather than the illness itself. Access to MAiD should not be granted and provided by health care practitioners to those with mental illness if their eligibility is the result of the actions of the health care providers themselves.

Overall, this criterion represents one of the largest barriers for individuals with mental illness who wish to access MAiD, because although their lifespan is shortened, their natural death may not be considered “reasonably foreseeable”. In fact, even the vast majority of “serious” mental illness

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147 As Frances has written:

Society would not tolerate 20 years of lost life expectancy for other groups, even those that also suffer discrimination like Latino or blacks or gays. If this were HIV or breast cancer or multiple sclerosis, we would not tolerate the total fragmentation of healthcare as we do with mental illness. We are complacent because the lives of those with severe mental illness do not matter to us. Unless the person dying young is your parent or your child, or your brother (supra note 113).


149 See ibid at 41–42.
conditions typically do not lead to a foreseeable natural death.\(^{150}\) As mentioned, however, the legislature included the foreseeable death requirement in the *Criminal Code* despite the SCC having omitted this requirement.\(^{151}\) *Carter* instead held that a grievous and irremediable condition is one which causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.\(^{152}\) This narrowing went against several concerns and recommendations which were raised during the debates of the Senate prior to passing Bill C-14.\(^{153}\) A consequence of this narrowing is that less individuals are eligible for MAiD. Although the individuals before the Court in *Carter* suffered from painful conditions, it was not clear that their deaths were more foreseeable than anyone else who will eventually die, and therefore they may not have been eligible for MAiD under the current provisions.\(^{154}\) Foregoing the foreseeable death requirement would facilitate access to MAiD by the mentally ill, whereas interpreting the *Criminal Code* more narrowly than *Carter* suggests a discord between the judiciary and the legislature.\(^{155}\)

### 5. Informed consent

The final potentially contentious eligibility criterion is that individuals must provide informed consent prior to receiving MAiD.\(^{156}\) The doctrine of informed consent requires that patients be informed and demonstrate an understanding of all material risks associated with a given procedure.\(^{157}\) The

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150 See Kirby, *supra* note 46 at 2 (an exception to this is terminal anorexia nervosa); Yarascavitch, *supra* note 54 at 17.

151 See *Carter, supra* note 11 at paras 127, 147 (the SCC chose to not consider the case of an applicant with mental illness).

152 See *ibid* at paras 127, 147.

153 See Senate Debate 1, *supra* note 2 at 751–52, 768. See also Kirby, *supra* note 46 at 2.

154 See *ibid* at para 17. See also HOC Debate, *supra* note 2 at 3855.

155 See Kirby, *supra* note 46 at 2.

156 See *Criminal Code, supra* note 8, s 241.2(1)(e).

Government of Canada has clarified that this means a patient can only give permission to receive MAiD after having received all of the information on his or her medical diagnosis and on any available forms of treatments and options to relieve suffering. This consent, which can be withdrawn at any time, must be given both at the time of the request for MAiD and immediately before MAiD is provided. Only upon receiving informed consent can a medical procedure be initiated.

Decision-making capacity is a core element of the doctrine of informed consent; to provide valid consent, a patient must have the mental capacity to do so. Although there is no single, uniform test for capacity in Canadian law, its definition is agreed upon across different jurisdictions. The primary focus of capacity rests on the patient’s ability to understand the relevant information and to appreciate the reasonable consequences of deciding to proceed with a given procedure or not. In particular, Ontario legislation regarding health care decision making defines capacity as follows:

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

In other words, if an individual does not understand the information provided to him or her regarding alternative options, or does not understand the consequences or impact of his or her decision to proceed with MAiD, then he or she does not have the capacity to consent to the procedure.

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160 See Hospitals Act, RSNS 1989, c 208, s 54; Substitute Decisions Act, 1992, SO 1992, c 30, s 47; Consent Act, supra note 157, s 4. See also CCA Report, supra note 4 at 56.

161 Consent Act, supra note 157, s 4.
Since mental illness can impact one’s state of mind, the fundamental question then becomes when, and under which circumstances, does a mentally ill individual have the mental capacity to consent to MAiD? The desire of a competent person to die may be considered rational if the unbearable suffering associated with mental illness prompts the suicidal wish and if there is very little hope for a better future. This question, however, continues to be debated; some mental health professionals believe that the desire to die is automatically irrational when one is diagnosed with a mental illness condition. Further, many people perceive death by suicide to be a direct consequence of mental illness.

Rationality is characterized by an individual portraying coherent thoughts and actions and having higher plans or goals. Irrationality, on the other hand, is generally thought to be evidenced through self-harming behaviours. As explained by Dr. Jeanette Hewitt, “irrationality rarely interferes with [one’s] rights of freedom unless accompanied by a diagnosis of mental illness.” The complication surrounding this criterion is therefore the idea that individuals may be incapable of truly understanding or appreciating the act of MAiD due to the effect of their mental illness condition on their decision-making capacity.

The interaction between mental illness and decision-making capacity is often difficult to disentangle. A mental illness condition could lead to a decline in the necessary cognitive abilities used for understanding and appreciating information, or it could impair mood and emotions, and thereby

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162 See Charland, supra note 159 at 3.
164 See ibid at 2. See also Henick, supra note 93.
165 See CCA Report, supra note 4 at 43.
167 See ibid.
168 See ibid.
169 See Charland, supra note 159 at 8. See also Yarascavitch, supra note 54 at 6, 8–9, 17.
impact one’s ability to make reasoned decisions. More specifically, Dr. Jeffrey Kirby explained that mentally ill individuals who experience active psychotic symptomatology, such as disturbances of thought and conceptual disorganization, may be more prone to struggle with the ability to understand their surrounding life circumstances and the consequences of certain health-related decisions. This is often generalized, however, and as a result, there is a common perception that people suffering from mental illness experience, as a symptom of the illness itself, distorted cognitions of hopelessness and the belief that their lives are worthless. In fact, Dr. Kirby maintains that many individuals with mental illness do retain the capacity to make informed health decisions.

The SCC has also recognized that people with mental illness are at risk of being unduly assumed to lack capacity. This perception must be met with caution and should not act as a barrier to individuals with mental illness in their pursuit of MAiD. Rather, fair assessments need to be conducted on a case-by-case basis. That said, even if an individual with a mental illness condition does have full decision-making capacity, it remains difficult for clinicians to be reasonably certain that the individual’s illness is not facilitating his or her request for MAiD.

Another issue, as explained by Dr. Louis C. Charland, is that the concept of “mental capacity” cannot be used uniformly in all situations. Capacity

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170 See CCA Report, supra note 4 at 64; Kirby, supra note 46 at 5; Yarascavitch, supra note 54 at 4–6; Scott Y H Kim, Raymond G De Vries & John R Peteet, “Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014” (2016) 73:4 JAMA Psychiatry 362 at 367. See also Schuklenk & van de Vathorst, supra note 74 at 580 (for a discussion on how depression significantly influences, or even determines, an individual’s view of reality, which may then ‘warp’ one’s request for MAiD).

171 See Kirby, supra note 46 at 5.

172 See Miller & Appelbaum, supra note 99 at 884.

173 See Kirby, supra note 46 at 5–6.

174 See CCA Report, supra note 4 at 57; Starson v Swayze, 2003 SCC 32 at para 77 [Starson].

175 See Miller & Appelbaum, supra note 99 at 884.

176 See Charland, supra note 159 at 3. See also Kirby, supra note 46 at 11; Yarascavitch, supra note 54 at 9.
assessments are performed for many different procedures. However, MAiD is a “drastic life-ending intervention,” thus the stakes are raised when capacity is used as a tool for accessing MAiD. When MAiD is requested on the basis of a mental illness condition that does not entail a reasonably foreseeable death, and that by definition is considered to be affecting the individual’s thinking and evaluations, then the stakes are likely to be raised even higher.

Further, it is possible that the medical practitioners who engage in such assessments could have an inherent bias that favours MAiD for mental illness, and thus may be more susceptible to view someone requesting MAiD as having capacity. This is unavoidable, however, and it is just as possible for bias to exist when MAiD is requested on the basis of a physical illness.

Overall, a mental illness diagnosis, on its own, is not sufficient to establish a lack of capacity. Rather, Canadian courts have held that a mentally ill patient may still maintain capacity and the cognitive ability to make informed decisions, including providing consent to terminating his or her life. Altogether, however, there does not seem to be any clear rule as to when a mentally ill individual might possess the capacity to consent, and achieving such an assessment may be difficult against the high stakes. The informed consent criterion must be carefully assessed on a case-by-case basis. No individual with a mental illness condition can be deemed to lack capacity on the basis of the mental illness diagnosis itself.

6. Summary: Eligibility criteria

A review of the MAiD criteria suggests that individuals with mental illness could be eligible for MAiD. Mental illness can often be declared as incurable, because it has no known cure, there is a contraindication to

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177 See Charland, supra note 159 at 3.

Mental illness is also known to cause a gradual decline in health, which can lead to an irreversible decline in capability and enduring suffering. Declining health can also result in a shortened lifespan, which – if interpreted liberally – might satisfy the reasonably foreseeable death criterion. Lastly, mental illness can impact mental capacity; however, the existence of the illness does not automatically imply that the individual lacks the capacity to consent to MAiD.

Generally, individuals with a serious mental illness condition can satisfy most, if not all, of the current eligibility requirements if they are in a very advanced state of the illness and have capacity. They therefore meet the standards that the government concluded were reasonable and acceptable circumstances for receiving MAiD.

However, the predominant barrier remains the “reasonably foreseeable death” criterion. If this criterion were omitted, thereby following the requirements set out in Carter, then mentally ill individuals would likely have greater access to MAiD. In contrast, the foreseeable death requirement in the Criminal Code hinders access to MAiD by the mentally ill. There are a number of individuals who, despite their suffering, may not satisfy all of the requirements at the same time. For example, a competent individual might be enduring suffering from a mental illness with no known cure, but their death might not be foreseeable yet. Such situations must be reassessed by the government to respect Charter rights.

C. Advantages of allowing greater access to MAiD

The predominant advantage of increasing the access of mentally ill individuals to MAiD is that it could make the Criminal Code more compliant with the Charter. The sections of the Charter that continue to be debated with respect to MAiD are section 7 (i.e., the right to life, liberty, and security of the person) and section 15 (i.e., the right to equality under the law). Upon reviewing each of these sections, I end with a discussion of whether the MAiD provisions would be saved by section 1 of the Charter.
1. Section 7: Life, liberty, and security of the person

In both Rodriguez and Carter, the SCC held that the original Criminal Code provisions violated section 7 of the Charter.\textsuperscript{179} Despite the decision in Carter and the subsequent enactment of the new Criminal Code provisions, Charter compliance has still been highly controversial.

Section 7 of the Charter states that “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”\textsuperscript{180} The first step of a section 7 analysis examines whether an individual or group is being deprived of a life, liberty, or security interest. I address each interest separately.

The right to life is engaged when the law inflicts, either directly or indirectly, an increased risk of death on a person.\textsuperscript{181} As MAiD deals with one’s choice to end his or her life, it directly engages the right to life.\textsuperscript{182} The SCC held that a prohibition on MAiD has the effect of forcing some individuals to end their lives prematurely, for fear that they would be incapable of doing so when they reach the point where suffering is intolerable.\textsuperscript{183} The SCC added that while a right to life primarily focuses on avoiding the imposition of death, it also includes a right to die with dignity.\textsuperscript{184}

Suicide is one of the top ten leading causes of death for people of all ages in Canada.\textsuperscript{185} The most common methods used are by hanging, which includes strangulation and suffocation, poisoning, and firearm use.\textsuperscript{186} The

\textsuperscript{179} See Rodriguez SCC, supra note 14 at 624; Charter, supra note 5, s 7; Criminal Code, supra note 8, s 241 as it appeared on May 2016.

\textsuperscript{180} Supra note 5, s 7.

\textsuperscript{181} See Carter, supra note 11 at 8–9.

\textsuperscript{182} See Lamb v Canada (AG), 2017 BCSC 1802 at para 22 (aff’d 2018 BCCA 266, leave to appeal to SCC refused); Firuz Rahimi, “Assisted Death in Canada: An Exploration of the Constitutionality of Bill C-14” (2017) 80:2 Sask L Rev 457 at 460.

\textsuperscript{183} See Carter, supra note 11 at para 57.

\textsuperscript{184} See ibid at para 60.

\textsuperscript{185} See Statistics Canada, Suicide Rates, supra note 129.

\textsuperscript{186} See ibid.
Senate discussed the issue of suicide prior to enacting Bill C-14 and recognized that the government forces some mentally ill individuals who are ineligible for MAiD to seek relief prematurely through “inhumane means”. The Senate also noted that some individuals who are already incapable of ending their lives on their own will have to engage in behaviours that cause further suffering, such as starving themselves, to meet the MAiD criteria.

Allowing the mentally ill to access MAiD would mean that their death by suicide would no longer need to be done in secrecy or isolation. Instead, access to MAiD would provide them with a more humane and less frightening death, which could be completed with greater dignity. In Dr. Lieve Thienpont’s study, which was conducted in Belgium, it was revealed that approximately 8% (4 of 52 participants) of those whose requests for MAiD were rejected later opted to die by suicide. The number of non-assisted suicides has decreased in Belgium by approximately 2% since the enactment of their MAiD legislation. Other jurisdictions, however, have experienced opposite results; the rate of non-assisted suicide in the Netherlands and in Luxembourg has actually increased since their MAiD legislation was introduced. These findings therefore challenge the theory that access to MAiD decreases non-assisted suicide rates.

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187 See Senate Debate 2, supra note 2 at 1231.
188 See ibid.
189 See Dembo, “MAiD Debate”, supra note 72; Rousseau et al, supra note 96 at 2.
191 Belgium’s MAiD legislation was enacted in 2002, and their crude suicide rate went from 22.7% in 2000 to 20.7% in 2016. The Netherland’s MAiD legislation was enacted in 2002, and their crude suicide rate went from 9.8% in 2000 to 12.6% in 2016. Luxembourg’s MAiD legislation was enacted in 2008, and their crude suicide rate went from 12.9% in 2010 to 13.5% in 2016. See “World Health Statistics Data Visualizations Dashboard” (last modified 2018), online: World Health Organization <apps.who.int/gho/data/node.sdg.3-4-data?lang=en> [perma.cc/XEW2-J8FV]; Theo Boer, “Does Euthanasia Have a Dampening Effect on Suicide Rates? Recent Experiences from the Netherlands” (2017) 10:2 J Ethics in Mental Health 1 at 6.
192 See Boer, supra note 191.
In the United States, Dr. David Albert Jones and Dr. David Paton conducted a study which examined the association between the legalization of MAiD and state-level suicide rates between 1990 and 2013. They found that while total suicide rates (including assisted suicide) rose after the MAiD legislation was introduced, the rate of non-assisted suicide remained constant. This suggests that even if MAiD is available, it may not actually reduce the rate of non-assisted suicide. However, this study only looked at suicide rates in the United States, and MAiD is not available there for individuals with mental illness as their sole underlying medical condition. The study also failed to control for mental health services, despite mental health being one of the most important risk factors for suicide.

Having the ability to navigate and respond to one’s medical condition is critical to one’s autonomy and thereby engages the right to liberty. The SCC held in *Carter* that the prohibition on MAiD deprived individuals of the ability to make “fundamentally” important and personal medical decisions. This has not changed with the enactment of the new *Criminal Code* provisions, since many individuals with mental illness remain ineligible for MAiD.

A capable mentally ill patient is allowed to refuse treatment and can consent to be discharged from a psychiatric facility, but he or she may not be able to request MAiD. In *Starson*, which dealt with an individual who wished to refuse medical treatment for his mental illness, the SCC held: “The right to refuse unwanted medical treatment is fundamental to a per-

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194 See Jones & Paton, supra note 193 at 602–603 (these results were obtained while controlling for various factors, unobservable state and year effects, and state-specific linear trends).

195 See Matthew P Lowe & Jocelyn Downie, “Does Legalization of Medical Assistance in Dying Affect Rates of Non-assisted Suicide?” (2017) 10:2 J Ethics in Mental Health 1 at 3–4 (the study by Jones & Paton, supra note 193 is “presented in such a way as to invite or allow misunderstanding and misrepresentation” at 5).

196 See *R v Morgentaler*, [1988] 1 SCR 30 at 166, 44 DLR (4th) 385 [*Morgentaler*].

197 See *Carter*, supra note 11 at paras 30, 65.

198 See *Starson*, supra note 174 at para 95; *Involuntary Psychiatric Treatment Act*, SNS 2005, c 42, s 6 [*IPTA*].
son’s dignity and autonomy. This right is equally important in the context of treatment for a mental illness.”

Although consenting to medical treatment is different from consenting to MAiD, the same basic conditions apply; in both situations, a capacity assessment must be completed by a medical practitioner. This similar line of thought was addressed by former Chief Justice McLachlin in Carter:

Logically speaking, there is no reason to think that the injured, ill and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying.

The law presumes each individual is capable of deciding whether to accept or reject medical treatment. As a result, patients with mental illness are presumptively entitled to make their own treatment decisions. Although Chief Justice McLachlin was referring to the “injured, ill and disabled” in general, this encompasses those with mental illness. Of importance is that patients with mental illness have the option to make other healthcare decisions, whereas they are more restricted from accessing the option of MAiD due to the specific eligibility criteria. It is unreasonable to restrict competent individuals from making one particular decision, namely with respect to MAiD, which is so fundamental to their well-being.

This argument does not apply, however, to individuals with mental illness who, as a result of the illness, do not have the option to make certain

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199 Starson, supra note 174 at para 75.
200 See Charland, supra note 159 at 3–4.
201 Carter, supra note 11 at para 115 [emphasis added].
202 See e.g. Consent Act, supra note 157, s 4.
203 This line of argument should not confuse capacity as a binary construct. Capacity is capable of changing over time, just as it is capable of differing based on the type of decision being made (e.g., an individual may be deemed to have capacity with respect to a treatment decision, yet simultaneously lack capacity with respect to hospitalization). Rather, this argument rests on the fact that if a patient has the option to make most other health care decisions, then they should not be restricted from contemplating MAiD.
health care decisions for themselves, such as in the case of involuntary treatments or admissions to psychiatric facilities if the individuals present a risk to themselves or others. While the right to make health care decisions is fundamental to one’s dignity and autonomy, in these instances, the well-being of patients who lack the capacity to make medical decisions depends upon state intervention. This is not the case, however, if the individual has capacity.

As noted by Mr. Murray Rankin, Québec Member of Parliament, the MAiD provisions assume everyone desires to live, regardless of their quality of life. This presumption does not allow individuals to make this choice for themselves. Ms. Camille Quenneville, Chief Executive Officer of the Canadian Mental Health Association, emphasized this point by stating “[w]ho are we to decide for them, and who are we to know how they are suffering? No one is in the position to say another must live the way they are.”

In Justice Wilson’s concurring opinion in Morgentaler, she maintained that the right to liberty grants individuals “a degree of autonomy in making decisions of fundamental personal importance.” Justice Wilson further stated that she believed the framers of the Constitution had in mind the freedom of the individual “to make his own choices for good or ill.” The ability to control the end of one’s life, particularly through the option of MAiD, is a fundamental medical decision. The current MAiD legislation deprives mentally ill individuals from making such decisions and this deprivation undermines their liberty interests.

In addition to the liberty interests of individuals seeking MAiD, the current MAiD legislation may also engage the liberty interests of third par-

204 See CCA Report, supra note 4 at 55; IPTA, supra note 198, s 17; Mental Health Act, RSO 1990, c M7, s 20(1.1).
205 See Starson, supra note 174 at para 75.
206 See HOC Debate, supra note 2 at 3806.
207 Camille Quenneville, “Mental Illness and Medical Assistance In Dying (MAiD) Debate” (Speaker Panel delivered at the Health Achieve Conference in Toronto, Ontario, 6 November 2017) [unpublished].
208 Morgentaler, supra note 196 at 166.
209 Ibid.
ties. Acts of MAiD fall under the provisions of the Criminal Code relating to homicide.\textsuperscript{210} Individuals who assist with the death of someone who is ineligible for MAiD can therefore face an indictable charge and be liable to imprisonment for a term of up to 14 years.\textsuperscript{211} The culpability of third parties has proven to be a concern,\textsuperscript{212} as was evidenced by the fact that four of the plaintiffs in the Carter case were third parties who were not suffering from an illness but wished to help those who were.\textsuperscript{213}

The last element of section 7 of the Charter, security of the person, is engaged when there is an interference with bodily integrity or dignity, or serious psychological stress.\textsuperscript{214} Carter outlined the options available to individuals without access to MAiD: “A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.”\textsuperscript{215} This scenario applies to the mentally ill. Due to the restrictions on their access to MAiD, mentally ill individuals are left to continue suffering from psychological pain and imposed stress, which directly affects their security of person.\textsuperscript{216}

The House of Commons outlined that additional options available to the mentally ill are to bring a Charter action or to begin a voluntary stopping of eating and drinking\textsuperscript{217} (VSED) in order to satisfy the reasonably foresee-

\textsuperscript{210} See Rodriguez CA, supra note 9.
\textsuperscript{211} See Criminal Code, supra note 8, s 241(1).
\textsuperscript{212} See Rahimi, supra note 182 at 464.
\textsuperscript{213} In addition to the original plaintiff, Gloria Taylor, the plaintiffs included Lee Carter, Hollis Johnson, Dr. William Shoichet, and the British Columbia Civil Liberties Association (BCCLA). Lee Carter and Hollis Johnson’s involvement arose after helping arrange an assisted death for Ms. Carter’s mother in Switzerland. Dr. William Shoichet was involved because he was willing to provide MAiD if it were not prohibited. The BCCLA’s interest was grounded in patients’ rights and health policy. See Carter Sup Ct, supra note 27 at paras 44–45.
\textsuperscript{214} See Morgentaler, supra note 196 at 173; Carter, supra note 11 at para 64.
\textsuperscript{215} Rodriguez SCC, supra note 14 at para 1.
\textsuperscript{216} See ibid at para 65.
\textsuperscript{217} Voluntary stopping of eating and drinking is a deliberate, self-initiated attempt to hasten death.
able natural death criterion. Indeed, VSED has been used in Canada as a pathway to obtain eligibility for MAiD. For example, Jean Brault, a 61-year-old from Québec, refused food for 53 days and water for eight days in order to become eligible for MAiD. Upon being told he finally met the eligibility criteria, Mr. Brault claimed he “felt liberated.” Similarly, a woman in British Columbia refused food and water for 14 days to qualify for MAiD. These options further impair one’s security by driving already ill individuals to engage in actions that could increase their psychological stress and physical pain and impair their bodily integrity.

For the foregoing reasons, the MAiD provisions deprive individuals with mental illness of their right to life, liberty, and security of the person. The next step in a section 7 Charter analysis is to confirm whether, on a balance of probabilities, the deprivation is caused by the state. Given that the deprivation is a direct result of the MAiD provisions enacted by the state, this part of the analysis may be answered in the affirmative. As a final step, it must be concluded that the section 7 violation is not in accordance with the principles of fundamental justice. While there are many principles of fundamental justice, I consider the principles against arbitrariness, overbreadth, vagueness, and gross disproportionality.

Arbitrariness

An arbitrary law is one that does not fulfil its purpose. One of the stated purposes for not extending the MAiD provisions to all individuals with

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218 See HOC Debate, supra note 2 at 3818, 3848.
219 See CCA Report, supra note 4 at 26.
222 See Morgentaler, supra note 196 at 174.
223 See ibid at 33, 56, 63.
224 See Carter, supra note 11 at para 83; Canada (AG) v Bedford, 2013 SCC 72 at para 111 [Bedford].
mental illness is to protect vulnerable individuals from ending their lives in a time of weakness while under the influence of their illness.\textsuperscript{225} A total ban for individuals with mental illness would achieve this purpose in a non-arbitrary manner, as was noted in \textit{Carter} prior to the enactment of \textit{Bill C-14}.\textsuperscript{226} However, even with the total ban having been replaced with the new \textit{Criminal Code} provisions, the legislation is still capable of achieving its objective of protecting the vulnerable in a non-arbitrary manner. Individuals with a physical illness \textit{and} a mental illness may be granted MAiD, as well as individuals with only a mental illness who meet the eligibility requirements. The requirements prevent the law from being arbitrary since those who are more significantly influenced by their illness would likely not be eligible.

It should also be understood that any patient can be vulnerable, whether the illness is physical or mental. If mentally ill patients were excluded as an entire category on the basis of their “vulnerability,” they would be denied the right to MAiD despite not necessarily being any more vulnerable than their physically ill counterparts. However, since they are eligible for MAiD so long as they meet the listed criteria, then there is no arbitrariness on the basis of their form of illness.

\textbf{Overbreadth}

Prior to \textit{Bill C-14}, the SCC held that the total prohibition on MAiD was overbroad in part because vulnerability can be assessed on an individual basis.\textsuperscript{227} With the total prohibition now removed and the eligibility requirements in its place, the MAiD provisions are aimed at capturing people directly within their purpose. Although this suggests that those who are deemed to be vulnerable will not be granted MAiD, the legislation also restricts the liberty of many individuals with mental illness who, but for the “reasonably foreseeable death” criterion, would otherwise be eligible for MAiD. There is no evidence that a reasonably foreseeable death is related to greater vulnerability. Therefore, the legislation “restricts liberty far more than is necessary to accomplish its goal” and thereby suffers from overbreadth.\textsuperscript{228}

\begin{itemize}
\item \textsuperscript{225} See \textit{Bill C-14, supra} note 1 at 1–2.
\item \textsuperscript{226} See \textit{Carter, supra} note 11 at para 84.
\item \textsuperscript{227} See \textit{ibid} at paras 86, 115.
\item \textsuperscript{228} \textit{R v Heywood}, [1994] 3 SCR 761 at para 48, 120 DLR (4th) 348.
\end{itemize}
Vagueness

There are several terms in the *Criminal Code* that are not defined. Professors Jocelyn Downie and Jennifer Chandler explain that the “capability” factor, for example, creates uncertainties as to whether the decline must be ongoing or stable, whether it is to be assessed by the patient or the physician, and whether it is to be assessed relative to the patient’s prior capability or to the general population’s capability.²²⁹ Likewise, the term “reasonably foreseeable” is vague, as it could refer to the probability that a person will die a natural versus an unnatural death, to the timing of a predicted death, or to the specific manner in which the person will die.²³⁰ The meaning of “intolerable suffering” can also be interpreted in several ways; it can refer to suffering that literally cannot be subjectively tolerated or to a specific intensity of suffering along a spectrum.²³¹

The vagueness of the terms used in the eligibility requirements could result in health care practitioners interpreting the criteria differently and, consequently, disagreeing as to whether an individual is, in fact, eligible for MAiD.²³² A law must be capable of being “identified with some precision” and “applied to situations in a manner which yields an understandable result.”²³³ Consistency is particularly crucial for a law that has a significant impact on individuals’ lives. It is therefore likely that the MAiD provisions in the *Criminal Code* violate the principle of vagueness.

Gross Disproportionality

A law exhibits gross disproportionality when the impact of the restriction on the individual’s life, liberty, or security of the person is grossly disproportionate to the object of the measure.²³⁴ The objectives of the MAiD provisions in the *Criminal Code* include protecting the vulnerable from “being induced, in moments of weakness, to end their lives”; affirming the “equal value of every person’s life”; avoiding “encouraging negative per-

²²⁹ See Downie & Chandler, supra note 123 at 23.
²³⁰ See *ibid* at 10; *Carter Sup Ct*, supra note 27 at 866.
²³¹ See Downie & Chandler, *supra* note 123 at 19.
²³² See e.g. *AB v Canada (AG)*, *supra* note 137 at para 1.
²³⁴ See *Bedford*, *supra* note 224 at para 35.
ceptions of the quality of life of persons who are elderly, ill, or disabled”; and recognizing suicide as a significant public health issue.235

These objectives are thought to be accomplished by restricting the eligibility for MAiD to exclude those who lack capacity or a reasonably foreseeable natural death. Predominant reasons for these restrictions include that (1) individuals may not be capable of understanding the consequences of MAiD as a result of their illness; and (2) a person who is granted access to MAiD for reasons of mental illness may go on to recover and no longer desire MAiD.236 For example, in a National Survey of Canadian Psychiatrists, 57% of respondents reported having treated patients whom they believed would have received MAiD were it legal for them, but instead went on to recover from their mental illness.237 A critique here, however, is that individuals in situations such as these would not have been eligible for MAiD, because the illness must be considered incurable.

As a result of the restrictions on eligibility, the MAiD provisions result in vulnerable people being left to suffer without any additional support measures. This was seen in Rodriguez and Carter, whereby the plaintiffs had no other option but to continue suffering until their muscle deterioration became so severe that it would lead to their eventual passing. A study by Dr. Scott Y H Kim et al. looked at assisted suicide in patients with mental illness in the Netherlands from 2011 to 2014 and found that most participants who requested MAiD had previously attempted suicide.238 If MAiD is not available, individuals who experience enduring suffering and who are committed to ending their lives might do so by inhumane means while they are still capable.239 This may strengthen the stigma surrounding the illness even more. Further, it is unreasonable to restrict access to MAiD on the basis that individuals might eventually recover.240

235 See Bill C-14, supra note 1.

236 See Rousseau et al, supra note 96 at 788, 791. This will be discussed in greater detail in the “Indecisiveness” Part below.

237 See ibid at 792.

238 See Kim, De Vries & Peteet, supra note 170 at 366.

239 See Rahimi, supra note 182 at 465.

240 See Schuklenk & van de Vathorst, supra note 74 at 578.
These effects are disproportionate to the objectives of the MAiD provisions and therefore violate the principle against gross disproportionality. Together, owing to their overbreadth, vagueness, and gross disproportionality, the MAiD provisions in the *Criminal Code* are likely not in accordance with the principles of fundamental justice, and thus violate section 7 of the *Charter*.

### 2. Section 15: Equality rights

Another relevant *Charter* provision is section 15, which states:

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.\(^{241}\)

Although a section 15 violation was raised in *Carter*, the SCC deemed it unnecessary to examine the issue in depth upon already having concluded there had been a section 7 violation.\(^{242}\) It has been extensively argued, however, that restricting the access of mentally ill individuals to MAiD results in discrimination on the basis of their illness.\(^{243}\)

By requiring an independent review specifically to address the issues surrounding mental illness and MAiD, *Bill C-14* distinguished individuals who have a physical illness as their sole underlying medical condition from those with a mental illness as the sole condition.\(^{244}\) Further, although MAiD is granted to anyone who satisfies the eligibility criteria, including those who have a mental illness, the criteria are much more difficult to meet when a mental illness is the sole underlying medical condition.\(^{245}\) This differential treatment does not necessarily suggest, however, that the law discrimina-

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\(^{241}\) See *Charter*, *supra* note 5, s 15(1).

\(^{242}\) See *Carter*, *supra* note 11 at para 93.

\(^{243}\) See e.g. Rahimi, *supra* note 182 at 474; CCA Report, *supra* note 4 at 15, 22.

\(^{244}\) See *Bill C-14*, *supra* note 1, s 9.1.

\(^{245}\) See CCA Report, *supra* note 4 at 63, 150, 192. See also CMHA, “Canadian Mental Health Association’s Position Paper on Medical Assistance in Dying”, Legislative Comment on Bill C-14, *An Act to amend the Criminal Code and to*
ates on the basis of mental illness; rather, it can be understood to protect the more vulnerable population. The latter position is supported by the fact that all MAiD applicants, regardless of their illness, must undergo multiple capacity assessments.

The “reasonably foreseeable death” criterion is more specific to physical illnesses and thereby results in a greater exclusion of mentally ill patients. Similar arguments have been raised before the SCC. In *AC v Manitoba (Director of Child and Family Services)*, for example, Justice Abella explained that when eligibility criteria for a program or benefit are based on an enumerated ground, the criteria are not discriminatory if they are merely being used to calibrate a separate factor. In that case, at issue was a provision that declared the age at which adolescents were mature enough to make their own treatment decisions. The SCC found that the provision was not discriminatory on the basis of age, because adolescents’ ability to make treatment decisions was calibrated based on maturity. The provision did not therefore promote a disadvantageous prejudice or stereotype. Similarly, MAiD provisions are calibrated to capture only those who have a serious illness but are still able to understand and appreciate the consequences of MAiD. While differential treatment may exist based on factors specific to mental illness, there is no evidence to suggest that this is being done in an arbitrary manner. According to this argument, mental illness is not being distinguished.

Alternatively, there is the argument that adverse effect discrimination is at play. By requiring the patient’s natural death to be reasonably foreseeable, the legislature has effectively created a distinction between forms of illnesses. It has excluded most individuals whose sole underlying medical condition is mental illness and who would otherwise be eligible for MAiD but for the reasonably foreseeable death criterion.

246 2009 SCC 30 at para 111.

247 *R v Kapp*, 2008 SCC 41 at para 3 [*Kapp*].

248 The concern that the “reasonably foreseeable death” criterion was unconstitutional was discussed prior to the enactment of *Bill C-14*: see Senate Debate 1, *supra* note 2 at 751–52, 754.
Adverse effect discrimination arises when a rule or standard, which is on its face neutral and equally applicable to all, in fact has a discriminatory effect on one group of individuals due to a special characteristic of the group and consequently imposes disadvantages, penalties, or restrictive conditions on the group which are not imposed on others. 249 The first step of the Kapp/Withler test for discrimination is to determine whether the law, “on its face or in its apparent effect, creates a distinction on the basis of an enumerated or analogous ground.” 250 As identified by the trial court in Carter, it “is not necessary for every member of a disadvantaged group to be affected the same way in order to establish that the law creates a distinction based upon an enumerated or analogous ground.” 251 Here, since some members with mental illness are being distinguished, the MAiD provisions create a distinction on the enumerated ground of disability.

Step two of the Kapp/Withler test assesses whether the distinction creates a disadvantage. 252 Here, the law perpetuates disadvantage, as those with mental illness are already disadvantaged by their illness and its stigma in society, and the law disadvantages them further by largely excluding them from accessing MAiD and forcing them to continue suffering. The law also engages in stereotyping by suggesting that individuals with mental illness who do not have a reasonably foreseeable death are not as worthy of being relieved of their suffering. Without a reasonably foreseeable death, many patients with mental illness are confronted with the same cruel options as Ms. Carter; that is, the options to take their own lives prematurely if possible or to continue suffering until death occurs from natural causes. As a result, the application of the “reasonably foreseeable death” criterion is more burdensome on individuals with mental illness than on those with a physical illness and thereby creates, by adverse effect, a distinction and disadvantage based on mental illness. Consequently, the same conclusion can be reached as that of the trial decision in Carter: the MAiD provisions “[perpetuate]
and [worsen] a disadvantage experienced by persons with disabilities” and therefore violate section 15(1) of the Charter.

3. Section 1 analysis

Overall, there are strong arguments that the current MAiD legislation violates the sections 7 and 15 Charter rights of individuals with mental illness who are incapable of satisfying all of the eligibility requirements for MAiD. The final stage in a Charter analysis considers the saving provision under section 1 and asks whether the Criminal Code provisions are rationally connected to their purpose, whether they are minimally impairing, and whether they are proportional to their effects.

The MAiD provisions legislate a pressing and substantial objective prescribed by law. This is clear considering the long history of MAiD debates stemming from Rodriguez. There is also a rational connection between the purpose of protecting the vulnerable and the provisions that result in the exclusion of individuals with certain mental illness conditions from accessing MAiD.

The minimal impairment inquiry asks whether there are less harmful means of achieving the legislative objective. In Carter, the SCC held that a blanket prohibition on MAiD is unnecessary, since medical practitioners can assess vulnerability and capacity on an individual basis. This can be distinguished here since there is no longer a blanket prohibition; as long as individuals meet the criteria, they can access MAiD. Instead, the issue has become one whereby people with serious mental illness conditions may be excluded merely because they do not satisfy the stringent criteria.

When ruling on the unconstitutionality of the prior prohibition, the SCC explained that we already have the resources and abilities required to complete individual assessments, so it is not unreasonable to add such a require-

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253 Carter Sup Ct, supra note 27 at para 1161.
255 See Rodriguez Sup Ct, supra note 12.
256 Carter, supra note 11 at paras 116, 119. See also Oakes, supra note 254 at paras 105–106, 115, 121.
While Carter did not look specifically at mental illness, this critique remains valid since vulnerability and capacity are elements in a mental illness diagnosis. This suggests that the main criterion remaining to be addressed is whether the individual’s death is reasonably foreseeable. It is not minimally impairing to exclude people with mental illness solely based on this criterion, because doing so disregards the fact that mental and physical illnesses can cause very similar levels of suffering despite potentially different long-term outcomes. Further, this goes against the legislature’s objective of recognizing all individuals as equal.

The MAiD legislation also fails to align with the legislator’s third objective of recognizing suicide as a significant public health issue; there is no strong evidence to suggest that extending the option of MAiD to individuals with mental illness would result in a significant number of them making use of the option. Only 3% of MAiD requests in Belgium, and less than 1% of the requests in the Netherlands, are by individuals with mental illness. These statistics also suggest that the eligibility requirements are unnecessarily restrictive, considering so few individuals actually seek MAiD when it is available to them. There is some concern, however, with regard to the number of requests for MAiD in these countries by people with mental illness that are later withdrawn before MAiD is administered. This number was as high as 38% for Belgian patients with mental illness. This finding suggests that the vulnerable population is at risk of being adversely affected by the MAiD legislation, since individuals might have gone on to withdraw their request for MAiD had they not received it.

With mental illness, there is the potential for some neuropsychiatric conditions to impact individuals’ decision-making capacity. It follows that the more complicated the decision – such as whether or not to seek MAiD

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257 See Carter, supra note 11 at para 115.
258 See Hospitals Act, supra note 160, s 54; Consent Act, supra note 157, s 4; DSM, supra note 6.
259 See Paul S Appelbaum, “Physician-Assisted Death for Patients with Mental Disorders—Reasons for Concern” (2016) 73:4 JAMA Psychiatry 325 at 325 (similar statistics could not be found for Luxembourg or Switzerland).
260 See ibid.
261 See ibid.
262 See Kim, De Vries & Peteet, supra note 170 at 367.
— the more this risk should be protected against. To help protect against it, however, is the MAiD criterion which requires a second medical or nurse practitioner to confirm in writing that the individual meets all of the eligibility criteria, including informed consent.\textsuperscript{263} In the Netherlands, three or more physicians were consulted during the evaluation stage in 33\% of MAiD requests for mental illness, and 24.2\% of MAiD requests for mental illness involved disagreements among physicians.\textsuperscript{264} While the disagreement supports restricting access to MAiD, requiring more consultations would be less impairing.

Overall, the minimal impairment inquiry of the section 1 analysis reveals that the “reasonably foreseeable death” criterion is not minimally impairing, but instead acts as a significant barrier to requests based on mental illness. As exemplified in the Netherlands, there are less harmful means of achieving the legislative goal.

The proportionality inquiry assesses whether the benefits of the law outweigh the negative effects produced by the limitation of the right. The benefits include protecting vulnerable individuals from ending their lives in a time of weakness while being potentially influenced by the symptoms of the illness itself. Mental illness is also a field that requires significantly more research, thus more stringent eligibility criteria may be favourable until more is known.

The negative effects, on the other hand, include that Charter rights are violated and the mentally ill are forced to continue suffering for an indefinite amount of time, despite their suffering being as severe as those who are deemed eligible for MAiD. An additional consequence of restricting access to the mentally ill is that the stigma that has long surrounded this population will be strengthened. Greater stigma further decreases individuals’ self-esteem and confidence, which exacerbates illness and increases the likelihood of relapse.\textsuperscript{265} Ultimately, their illness could worsen while they remain ineligible for MAiD. The benefits, while valid and important, do not outweigh the serious consequences.

\textsuperscript{263} See \textit{Criminal Code}, supra note 8, s 241.2(3)(e).

\textsuperscript{264} See Kim, De Vries & Peteet, supra note 170 at 367.

\textsuperscript{265} See Chandler & Flood, supra note 140 at 47.
4. Summary: Charter rights

While this is a very brief overview of the Charter infringement analysis, most of the arguments presented suggest that section 7 and section 15 have been violated, and that such violations would not be saved by section 1. Broadening the criteria in the Criminal Code so that more individuals with mental illness could access MAiD would therefore result in more Charter-compliant legislation.

D. Disadvantages of allowing greater access to MAiD

Three of the predominant disadvantages of increasing access to MAiD are the potential for greater ambivalence among some individuals with mental illness, the fact that not enough preventative and support measures are currently in place for the mentally ill population, and that adequate healthcare is often inaccessible. These factors could result in mentally ill individuals receiving MAiD despite potentially having changed their mind had they had more time or without having received adequate support prior to the decision.

1. Indecisiveness

The Criminal Code mandates a ten-day waiting period between the date that MAiD is requested and the date that MAiD is received.\(^\text{266}\) It further requires that, immediately before receiving MAiD, patients be given another opportunity to either withdraw their request or to provide additional express consent.\(^\text{267}\) These are used as safeguards to help ensure that patients are satisfied with their decision to proceed with their request.

In Canada, reports have shown that less than 10% of requests are withdrawn by people with a physical illness during this waiting period.\(^\text{268}\) In comparison, it was found in Belgium that 49% of requests made by in-

\(^{266}\) See Criminal Code, supra note 8, s 241.2(3)(g).

\(^{267}\) See ibid, s 241.2(3)(h).

dividuals with mental illness were later withdrawn.\textsuperscript{269} This Belgian study followed 100 mentally ill individuals over the course of one year.\textsuperscript{270} It was found that 38 patients withdrew their request before a decision was reached – and of the 48 patients whose requests were accepted – 11 of them chose to postpone or cancel the procedure.\textsuperscript{271} While these numbers may be reflective of the indecisiveness of the participants, they may also be reflective of problematic assessments by the psychiatrist. In other words, the large number of withdrawals suggests that the psychiatrist did not accurately assess the eligibility criteria for MAiD, including that the illness was incurable and caused enduring suffering. It was also recognized as a limitation that the sample in the study might not be representative of similar patients.\textsuperscript{272}

Another study, which looked specifically at individuals who used MAiD in the Netherlands and Belgium based on a diagnosis of personality disorders, found that they represented 52\% of the Dutch cases and 50\% of the Belgian cases.\textsuperscript{273} Of concern is that personality disorders are often associated with strong reactivity to environmental stimuli, which, as Appelbaum noted, “raises questions about the stability of the expressed desire to die.”\textsuperscript{274}

Although there is little research on the impact of mental illness on the stability of one’s preferences, these statistics reveal a possibility that – with additional time and support – a patient who has requested MAiD might ultimately retract their request. More research needs to be conducted, however, on what it is that actually influences one’s decision over time and whether there are other common types of mental illness conditions that are associated with withdrawn requests.

Some mental health practitioners and advocates argue that individuals who survive a non-assisted suicide attempt later express gratitude that they did not succeed and are still alive.\textsuperscript{275} There is also some evidence that patients who are involuntarily treated for their mental illness will usually

\textsuperscript{269} See Thienpont, \textit{supra} note 190 at 5.
\textsuperscript{270} See \textit{ibid}.
\textsuperscript{271} See \textit{ibid} at 5–6.
\textsuperscript{272} See \textit{ibid} at 6.
\textsuperscript{273} See Appelbaum, \textit{supra} note 259 at 325.
\textsuperscript{274} Ibid.
\textsuperscript{275} See Dembo, “Addressing Treatment”, \textit{supra} note 163 at 2; Henick, \textit{supra} note
agree, once their symptoms have improved, that treatment was the best option.\textsuperscript{276} These findings support the position that mentally ill individuals may be more likely to change their mind about dying. As a result, impeding their access to MAiD could be protecting them from a desire that might be temporary. There is, however, a significant bias here, considering that the feelings of those who have succeeded in ending their lives – either by non-assisted suicide or by MAiD – cannot be inquired.

There is also a distinction between MAiD and suicide that must be recognized when posing the indecisiveness argument; while MAiD has several safeguards in place which help to ensure that individuals have capacity and an incurable illness, those who attempt non-assisted suicide might not always appreciate and understand the consequences of their actions at the time of the attempt, nor might they recognize that they can be treated.\textsuperscript{277} This is not to suggest that those who receive MAiD and those who die by non-assisted suicide are different populations. Not having access to MAiD may force individuals with incurable mental illness to end their lives by suicide, at which point they may still have the necessary capacity and understanding. Similarly, those who do not succeed with non-assisted suicide may later opt for MAiD.\textsuperscript{278} The difference in approach with respect to the safeguards is vital to recognize though, as it helps to ensure that those who receive MAiD are, in fact, suffering from an incurable illness, and are in a position to appreciate the consequences of MAiD.

2. Preventative and supportive measures

Mental illness develops as a result of psychological, biological, as well as social factors. The social problems must be accounted for. Importantly, efforts to broaden access to MAiD should guard against the use of MAiD as a substitute for psychosocial intervention and support.\textsuperscript{279} This concern

\begin{itemize}
\item 93. See also CCA Report, \textit{supra} note 4 at 170; Schuklenk & van de Vathorst, \textit{supra} note 74 at 580.
\item \textsuperscript{276} See CCA Report, \textit{supra} note 4 at 106.
\item \textsuperscript{277} While there are safeguards to help ensure capacity exists, they are difficult to conduct in a consistent and effective manner. See Charland, \textit{supra} note 159 at 8.
\item \textsuperscript{278} See Kim, De Vries & Peteet, \textit{supra} note 170 at 366.
\item \textsuperscript{279} CMHA, \textquotedblleft Position Paper\textquotedblright, \textit{supra} note 245; Schuklenk & van de Vathorst, \textit{supra}
was raised by Dr. Paul S Appelbaum, who noted that 20% of MAiD patients in the Netherlands never had a psychiatric hospitalization, thereby suggesting that the administration of MAiD may have served as a substitute for intervention and support. A similar concern may also arise the context of physical illness, as having MAiD as an end-of-life option may result in medical practitioners being less concerned about providing high-quality care. Conversely, it is also possible that physicians may work harder to ensure the appropriate supports are in place if MAiD is an option.

There are currently limited health care supports available for those suffering from mental illness. Approximately one-third of mentally ill individuals over the age of fifteen do not receive adequate care. When they do, wait times for counselling and therapy are often between six months to one year. During this time, their illness could worsen. These deficiencies are in part due to the fact that mental health care is underfunded by approximately $1.5 billion. This presents a significant concern, particularly due to the consistent finding that social support is important for coping with mental illness. In particular, social support helps to improve functioning

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note 74 at 581–582. See also Miller & Appelbaum, supra note 99 at 884.

280 See Appelbaum, supra note 259 at 325. See also CCA Report, supra note 4 at 49 (also of concern in the Netherlands is that a lack of socio-economic resources may contribute to one’s suffering).

281 See Miller & Appelbaum, supra note 99 (a clinician may not be willing to comply with a request for MAiD due to it being countertherapeutic, considering “it involves an implicit endorsement of the patient’s perspective that his or her life is worthless and there is no hope for improvement” at 884).

282 See Adam Sunderland & Leanne Findlay, “Perceived Need for Mental Health Care in Canada: Results from the 2012 Canadian Community Health Survey – Mental Health” (2013) 24:9 Statistics Canada Catalogue No.82-003-X 3 at 8. See also CAMH, supra note 114.

283 See CAMH, supra note 114.

284 See ibid.

by influencing the stress appraisal process and consequently increasing motivation.\textsuperscript{286}

With this in mind, Members of Parliament and health professionals have suggested that the shortcomings of mental health treatments should be addressed \textit{before} the availability of MAiD is broadened.\textsuperscript{287} There is especially a need for more investment in mental health supports, in better early intervention and prevention support strategies, as well as in a national suicide prevention strategy.\textsuperscript{288} Parliament restricted the use of MAiD for mental illness partially for this reason.\textsuperscript{289}

Lastly, since mentally ill individuals may experience hopelessness regarding the possibilities of effective treatment, treatment regimens for mental illness focus largely on providing support and offering hope to those who are suffering.\textsuperscript{290} Broadening access to MAiD to include more mentally ill individuals could contradict these efforts.\textsuperscript{291} Patients may consider MAiD as an easier alternative to burdensome therapy that has no guarantee of future success.\textsuperscript{292} Of course, there are still certain types of mental illness that are incurable and result in severe suffering, which no amount of support can assist. However, this again raises the issue that individuals who are suffering from an incurable illness are difficult to ascertain due to the unpredictable nature of mental illness.\textsuperscript{293}

3. \textbf{Inaccessibility of health care}

Similar to the issue of limited preventative and support measures, another issue for mentally ill individuals is that the availability of psychological

\begin{footnotes}
\footnote{286}{Davis & Brekke, \textit{supra} note 285 at 43.}
\footnote{287}{See Senate Debate 2, \textit{supra} note 2 at 1234; Quenneville, \textit{supra} note 207.}
\footnote{288}{See Quenneville, \textit{supra} note 207; Tayebeh Fasihi Harandi et al, \textit{supra} note 285 at 5218.}
\footnote{289}{See Boer, \textit{supra} note 191 at 5.}
\footnote{290}{See \textit{ibid}.}
\footnote{291}{See HOC Debate, \textit{supra} note 2 at 3824; Henick, \textit{supra} note 93.}
\footnote{292}{See Boer, \textit{supra} note 191 at 5.}
\footnote{293}{See CCA Report, \textit{supra} note 4 at 34, 38–39.}
\end{footnotes}
services across Canada is lacking and varies greatly from place to place. A study performed by Dr. Amelia Gulliver et al. sought to identify treatment barriers for individuals with mental illness and noted that lack of accessibility was a recurring theme. Time, transportation, costs, and inconvenience contributed to lack of accessibility. A scarcity of mental health professionals also made it difficult for individuals to access help. This theme, which was particularly strong in rural populations, was identified by participants in 30.8% of the studies conducted, thereby marking it as the eighth most common barrier. This finding aligns with the results of the CCA report, which reveal that in 2013, approximately 29% of Canadians aged 15 or older who required health care experienced difficulty in accessing such services, and in 2012, 26.3% of people in Canada aged 12 and older reported not having received mental health care despite their perceived need for it.

With respect to the cost of mental health services, Dr. Nursel Topkaya identified high fees and a lack of state reimbursement as some of the strongest barriers to treatment. Although this was not a Canadian study, the factors are still relevant since services of psychologists are not funded by provincial health insurance plans in Canada. The cost of mental health treatments can therefore make treatments particularly inaccessible to Canadians with modest incomes or no health insurance coverage. Cost is also an issue in remote areas of Canada whereby one must travel long distances to access mental health services.

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294 See “Treatment for Mental Health Problems/Illnesses is More Than Just Medication” (8 February 2015), online (blog): Canadian Alliance on Mental Illness and Mental Health <www.camimh.ca/treatment-for-mental-health-problemsillnesses-is-more-than-just-medication/> [perma.cc/4PBX-F9Z4] [CAMIMH]. See also CCA Report, supra note 4 at 48-49; Yarascavitch, supra note 54 at 27–28.


296 See CCA Report, supra note 4 at 26, 48.

297 See Nursel Topkaya, “Factors Influencing Psychological Help Seeking in Adults: A Qualitative Study” (2015) 15:1 Educational Sciences: Theory & Practice 21 at 29 (this study was conducted in Turkey).

298 See CAMIMH, supra note 293.

299 See CCA Report, supra note 4 at 26.
Between the lack of preventative and supportive measures and inaccessibility, a concern emerges that governments with MAiD legislation have their priorities wrong.\textsuperscript{300} MAiD should not be extended without first dealing with the issue of inadequate health care. This concern applies to individuals with physical illness as well; if treatment is inaccessible, then efforts should first be made to make it accessible before health care providers offer MAiD. Absent such measures, deaths pursuant to MAiD may be unjust and premature. A counter-argument, however, is that the legislature has no right to force individuals to continue living while it attempts to gradually improve access to health care.\textsuperscript{301}

\section*{Conclusion: Future Directions}

This paper sought to identify how the current eligibility criteria exclude a large proportion of people who suffer from mental illness and suggests that the criteria should therefore be amended to be more \textit{Charter}-compliant. The federal government should address and broaden the problematic areas of the legislative framework so as to facilitate access to MAiD for mentally ill individuals, while also implementing additional safeguards for the mentally ill.

The eligibility criteria must be interpreted with mental illness in mind. Mental illness \textit{can} be serious and incurable, \textit{can} result in an irreversible decline in capability, and \textit{can} result in enduring suffering. The requirement that the individual’s natural death be foreseeable remains contentious, however, along with the individual’s ability to give informed consent.

In its current form, the “reasonably foreseeable death” criterion impedes individuals with mental illness – whom are suffering to the same extent as those with a physical illness – from accessing MAiD, simply because the time they have left to live is not foreseeably limited. The relevant \textit{Criminal Code} provisions are therefore illogical, considering they only relieve the suffering of those who will not suffer for much longer. Individuals who may continue to suffer for several more years, however, are left unattended. A larger emphasis should thus be placed on relieving long-term suffering. To this end, the requirement of a “reasonably foreseeable death” should be omitted.

\textsuperscript{300} See Schuklenk \& van de Vathorst, \textit{supra} note 74 at 582.

\textsuperscript{301} See \textit{ibid}.  

The informed consent doctrine remains valuable so long as it assesses individuals on a case-by-case basis and does not exclude patients solely because they have a mental illness. This criterion should therefore continue to assess capacity based on the current standards, whereby individuals are deemed to have the capacity to consent if they are able to fully understand and appreciate the condition they have, as well as the nature and consequences of MAiD, including its material risks and benefits.302 Patients should also be sufficiently competent to understand and evaluate their prognosis based on the scientific evidence and on the state of Canadian health care at the time MAiD is requested.303 In other words, the prospect of potential future developments in science and health care should not be a barrier to present-day requests for MAiD. Further, due to the challenges inherent in assessing the capacity of individuals with mental illness, including the increased likelihood of fluctuation in symptom intensity, it is important that these capacity assessments are conducted by experienced psychiatrists, psychologists, social workers, and/or other regulated health professionals with relevant training and expertise.304

As for Charter compliance and the preservation of fundamental rights, the advantages of the MAiD legislation appear to outweigh the disadvantages. To combat the disadvantages, the legislature must enact appropriate safeguards. Such safeguards could include a longer waiting period and a requirement for counselling during this time.305 This would also help address the shortcomings of mental health support. Studies conducted in Belgium suggest that the current 10-day waiting period enforced by the Criminal Code may not be sufficient.306 A longer delay would help ensure that the individuals who may change their mind and withdraw their MAiD request have time to do so. In Belgium, the waiting period is extended to one month if an individual’s death is not reasonably foreseeable.307 Due to the large

302 See IPTA, supra note 197, s 18; Dembo, “MAiD Debate”, supra note 72; Schuklenk & van de Vathorst, supra note 74 at 582.

303 Schuklenk & van de Vathorst, supra note 74 at 582, 584.

304 See Kirby, supra note 46 at 11, 13. See also CCA Report, supra note 4 at 178–80.

305 See Dembo, “MAiD Debate”, supra note 72. See also CCA Report, supra note 4 at 184.

306 See Criminal Code, supra note 8, s 241.2(3)(g). See also CCA Report, supra note 4 at 184.

307 See Belgian Act, supra note 48, s 3(3).
range of mental illness conditions and their relative severities, the length of delay might be most appropriately assessed on an individual basis. It is critical, however, that the length of the waiting period be balanced with the suffering that the individual must continue to endure while waiting for MAiD.\textsuperscript{308}

A further safeguard to ensure that the incurability and enduring suffering criteria are met could be to require either a certain number of treatment failures, or a certain length of time that the individual has been suffering from the mental illness.\textsuperscript{309} This would be similar to an approach taken in Belgium, whereby a patient is deemed untreatable only after all standard biological, psychotherapeutic, and social interventions have been attempted.\textsuperscript{310} However, this approach could result in a form of discrimination based on access to mental health care. As noted above, mental health treatments and support can be hard to obtain, and such a requirement may therefore disadvantage the most vulnerable or underprivileged individuals. A more thorough analysis of this requirement is needed. Alternatively, the requirement could be based on a repeated number of MAiD requests over a period of time determined to be reasonable in the circumstances.\textsuperscript{311}

Overall, there are several possible safeguards that could be put in place. Doing so would allow MAiD to be accessed by more individuals suffering from serious mental illness without violating the purposes of the MAiD provisions in the \textit{Criminal Code}.

\textsuperscript{308} See Thienpont, \textit{supra} note 190 at 5 (four percent of those approved for MAiD – 2 of 48 participants – died by suicide during the waiting period).

\textsuperscript{309} See Dembo, “MAiD Debate”, \textit{supra} note 72. See also CCA Report, \textit{supra} note 4 at 186.

\textsuperscript{310} See CCA Report, \textit{supra} note 4 at 185–86.

\textsuperscript{311} See Schuklenk & van de Vathorst, \textit{supra} note 74 at 582.