

Medical Assistance in Dying Legislation: Mental Health Considerations

ABRIDGED BRIEF

The mental health community has fought a long time to overcome discrimination, and for physical and mental illnesses to be considered equal in law. However, the proposal by the Joint Committee to include psychological conditions alone in medically assisted dying legislation raised legitimate issues with regard to the distinct vulnerabilities of people living with mental health problems and illnesses, their caregivers and clinicians. There are unique social, political, legal, and ethical complexities that surround end-of-life in the context of mental health, on which there has not yet been an adequate national conversation, especially with the people living with mental health problems, their families and caregivers, and health professionals. Given that currently, as few as 1 in 4 people with mental health problems and illnesses get help, we need to give additional thought to evidence based measures that will protect them when they are at their most vulnerable.

The Mental Health Commission of Canada (MHCC) is committed to eliminating stigma, improving access to services for people and families living with mental health problems and illnesses, and promoting the well-being of all people in Canada, as outlined in the *Mental Health Strategy for Canada*. Its foundational principles include a focus on recovery – a principle that encompasses self-determination, choice and hope, promoting mental health and wellness, respecting diversity and addressing inequities, including families and caregivers in care and decision-making, informed action based on diverse sources of evidence and knowledge, and fully including people living with mental health problems and illnesses in society.

Recommendations

The MHCC supports the decision to take a phased approach to Bill C-14. Adequate time is needed to facilitate a comprehensive national conversation about acceptable safeguards in the availability of medically assisted dying for those suffering from psychological or mental health conditions alone, so as to minimize negative impacts on people living with mental health problems and illnesses when they are most vulnerable, and on their caregivers and health professionals. These should at least include:

1. Adequate access to recovery-oriented mental health services across the country. People with mental health problems and illnesses should have reasonable opportunities for recovery and wellness, including in relation to social determinants that affect their mental health. Lack of access to mental health services can cause the same despair for people with mental health problems and illnesses as not having access to palliative care does for people with incurable physical conditions.
2. Emphasizing the parallel importance of suicide prevention through concurrent suicide prevention initiatives, along with education about differences between suicide and medical assistance in dying.

3. Holding a national conversation, in which people living with mental health problems and illnesses and experiences with suicide play a central role, about mechanisms to minimize risk of wrongful death, which, in our view, should minimally include:
 - a) Ensuring there is a clear and informed choice through an assessment that:
 - o is made by two qualified mental health professionals, one of which is a mental health professional without prior involvement in the care of the patient, and
 - o includes information about previous treatments, whether appropriate services have been available, the person's special circumstances, and a discussion about options.
 - b) A reflection period. If the assessment reveals evidence of undue influence, a second evaluation with an additional reflection period is invoked.
 - c) Appropriate documentation and reporting.
 - d) Ensuring that those denied medical assistance in dying receive ongoing, follow-up care.
 - e) Clarifying roles and responsibilities for all clinicians involved.
 - f) Defining the essential parameters for the threshold of irremediable mental health conditions, potentially in the form of guidelines.
 - g) Guidelines for the use of advance directives.
4. Training for clinicians and administrators.
5. A national mechanism to monitor, evaluate, and research how the lives of people who have applied for medical assistance in dying are affected, including history of service access, and particular experiences of racialized groups and other distinct populations.
6. Governments work in partnership with Indigenous leaders to understand the unique perspectives of First Nations, Inuit and Métis, including special consideration of their experiences and communities.
7. Protecting the psychological health and safety of health care professionals involved in delivering medical assistance in dying, including education and awareness-raising.
8. Appropriate supports and services for caregivers and family members.
9. Protocols in situations where someone asks for medical assistance in dying and does not want anyone in their life to know.
10. Application of the Health Equity Impact Assessment for developing medical assistance in dying policies and programs.