Mental Health and MAID

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Abstract

This paper considers the roll-out of Medical Assistance in Dying (MAID) for individuals with mental disorders. First, an overview of the Carter decision is provided before moving into an analysis of what a hypothetical prohibition on MAID for individual with mental disorders would be viewed constitutionally. The paper then examines the present safeguards for accessing MAID, and what issues providing access for those with mental disorders might present. The paper ends with policy recommendations based on other jurisdictions current practices.

Introduction

The release of the Supreme Court of Canada's decision in *Carter*[1] has given rise to substantial debate about Medical Assistance in Dying (MAID) among advocates and academics. These debates concern the parameters of who should be eligible for MAID, or what eligibility should look like. In response to *Carter*, the Government of Canada drafted legislation to allow those people who are terminally ill to access MAID, however they delayed those with mental disorders from being able to access it.[2] On March 17, 2023, that changes. Soon, those whose only "grievous and irremediable" medical condition is a mental disorder can access MAID, provided they meet all other eligibility criteria.[3]

In anticipation of the eligibility expansion, there have been several controversial media stories about individuals who are accessing MAID because of depression,[4] or even because they face homelessness.[5] Indeed, these stories led to calls from many to reconsider MAID for those only with mental disorders.[6] With concerns around those individuals accessing MAID growing, it is not unreasonable to conceive that a future federal government will look to remove access. If that were to happen, a prospective *Charter* challenge would almost certainly follow. While the *Carter* decision provides a useful lens to evaluate a potential section 7 challenge against a

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1 *Carter v Canada* (Attorney General), 2015 SCC 5 [*Carter*].
2 Government of Canada, "Medical assistance in dying" (July 7, 2022) *About medical assistance in dying.* [*Canada MAID*] online: <www.canada.ca/en/health-canada/services/medical-assistance-dying.html>.
3 Government of Canada, "Canada's new medical assistance in dying" (July 7, 2021) *Changes to*

eligibility criteria. [*Canada New MAID*] online: <www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html>.
[4] Erin Anderssen, "Canada will soon allow medically assisted dying for mental illness. Has there been enough time to get it right?" *The Globe and Mail* (November 11, 2022), online: <www.theglobeandmail.com/canada/article- maid-canada-mental-health-law/>.
[5] Hannah Alberga, "Toronto woman in final stages of MAiD application after nearly a decade-long search for housing" *CTV News Toronto* (November 15, 2022) online: <toronto.ctvnews.ca/toronto-woman-in-final-stages-of- maid-application-after-nearly-a-decade-long-search-for-housing-1.6145487>.
[6] "Globe readers have a lot of feelings about Canada's controversial MAID law. Here's what you had to tell us" *The Globe and Mail* (November 15, 2022), online: <www.theglobeandmail.com/canada/article-maid-canada-mental- health-reader-reaction/>.

prohibition of MAID for those with mental disorders, the analysis is more complex because of the challenges of evaluating decision-making capacity. This paper begins by examining the *Carter* decision and the principles of fundamental justice analysis, and then considers several issues identified by academics related to decision-making capacity. Using *Carter* as a guide, a prohibition on MAID for those with mental disorders is examined through the lens of a section 7 *Charter* challenge. Through examination of decision-making capacity with respect to depression, dementia, and other psychiatric disorders, it is likely that a prohibition on MAID for those only suffering from mental disorders would not withstand a section 7 *Charter* challenge and be declared unconstitutional. Finally, policy and guideline recommendations to protect vulnerable groups from the issues identified by scholars are considered.

The Carter Decision

Prior to *Carter*, it was a crime to help another person end their own life.[7] This meant someone suffering from Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), as was the case in *Carter*, would be faced with the decision to end their life while they had the physical capacity to or to suffer for an undetermined amount of time before they pass. The provision preventing assistance in dying was challenged by Lee Carter and Gloria Taylor on the grounds that their section 7 rights under the *Charter* were violated. The Supreme Court of Canada in a unanimous decision found that the provision did violate section 7 of the *Charter*.[8] The Court evaluated the prohibition against the principles of fundamental justice. The law against assisted dying was found to be in accordance with the principle of fundamental justice against arbitrariness. The

[7] *Carter supra* note 1 at para 1.
[8] *Ibid* at para 56.

objective of the prohibition was to protect vulnerable people, which is connected to the function of the prohibition.[9]

However, the prohibition was found to violate the principle of overbreadth. A law is overboard when it captures conduct that is not connected to the legislative objective. The law was found to be overbroad because while the legislative objective was to project vulnerable persons, it was capturing people who were not vulnerable.[10] The Court found that Ms. Carter was someone who had thoughtfully considered her reasons for wanting to die and wanted assistance in doing so. She was not vulnerable.[11] The law captured her conduct which was not its objective, and thus was found to be a violation of her section 7 rights. The Court also noted that while it was unnecessary to determine whether the principle of gross disproportionality was breached,[12] had they considered it, the imposition of unnecessary suffering on an individual would be weighed against the high importance of protecting vulnerable people. The provision was unable to be saved by section 1, as it was found to not be minimally impairing.[13]

The Supreme Court also highlighted that many of the concerns related to the "slippery slope" were able to be addressed by a regulatory framework[14] or physicians acting as gatekeepers.[15] The analysis regarding the principles of fundamental justice, as well as the reliance on physicians as capable to assess capacity, will become key in examining MAID for those with mental disorders.

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[9] *Carter supra* note 1 at para 83.
[10] *Ibid* at para 85.
[11] *Ibid* at para 86.
[12] *Ibid* at para 90.
[13] *Ibid* at para 121.
[14] *Ibid* at para 117.
[15] *Ibid* at para 116.

Issues with Capacity in Mental Health

To be eligible for MAID, the person requesting access must be deemed capable of providing informed consent. In instances of someone having a terminal physical illness, being capable of giving informed consent is less of a challenge for physicians to assess as they are already able to provide consent on treatment.[16] With mental disorders, however, capacity can be much more difficult to evaluate for several reasons.

Emotional State Effects Decision Making

The first challenge involves how emotional state is factored into the assessment tool to measure competency, which is illustrated by examining the MacArthur Treatment Competence Assessment Tool (MacArthur). The MacArthur is a semi-structured assessment tool which measures competence at a specific point in time in a specific context.[17] Competency is measured by evaluating four cognitive abilities: understanding the facts involved in the decision, appreciating the facts and the decision, being able to rationally weigh the consequences, and expressing a decision.[18] The MacArthur benefits from being tailored to comply with the law on consent, however that compliance comes at a cost. Unlike the Mini-Mental Examination, which examines global competency, the MacArthur does not capture the full scope of human decision making;[19] it does not consider how emotions like hope or anger factor into its assessment.[20] This presents a particular issue for measuring capacity for those suffering from mental disorders like depression.

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[16] *Ibid* at para 115.
[17] Louic C Charland, Trudo Lemmens LicJur & Kyoko Wada, "Decision Making Capacity to Consent to Medical Assistance in Dying for Persons with Mental Disorders" (2016) page 4 (Journal of Ethics in Mental Health) [*Charland*].
[18] *Charland supra* note 17 at page 5.
[19] *Ibid.*
[20] *Ibid.*

Unlike suffering from a terminal physical disease with no possible treatment option, depression can be treated with medication or other psychotherapies. Moreover, part of the diagnostic criteria for depression is continued feelings of hopelessness.[21] By not measuring how emotions such as hope factor into decision making, the MacArthur is susceptible to evaluating someone at their lowest point without any indication or warning signs. Part of the assessment involves measuring whether the person can rationally weigh the consequences of their decision.[22] Not knowing the extent to which emotion might be impacting their choice poses a problem. To be sure, supporters of MAID for those with depression or similar mental health challenges could argue that when individuals "return to baseline" in terms of hope, they can simply withdraw consent and not continue with MAID. The challenge is that hope and other emotions are a factor in treatment decisions.[23] It is not difficult to imagine questions being raised about how a person might have considered changing medication or a different type of psychotherapy if they were not at their lowest point. In *Carter,* the Supreme Court did not condition access to MAID on requiring patients to undergo treatments they deemed to be unacceptable.[24] But how does their emotional state impact the patient's determination of what is unacceptable? When considering a decision as serious as accessing MAID, the scrutiny given to the decision should be high and include emotional assessments. This is presently not done through a standardized assessment.

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[21] Mayo Clinic, "Depression (major depressive disorder)" online: <www.mayoclinic.org/diseases- conditions/depression/symptoms-causes/syc-20356007>.
[22] *Charland supra* note 17 at page 5.
[23] *Ibid.*
[24] *Carter supra* note 1 at para 127.

The Capacity to Consent Changes Over Time

The second challenge is how capacity changes over time. With terminal illnesses, capacity deteriorating over time, or shifting suddenly, is not as pressing of a concern compared to mental health. Patients suffering from ALS for instance are commonly lucid and fully capable of making informed decisions well after they lose physical capacity. Indeed, the point of MAID for individuals like Ms. Carter is to end their life before they get to the stage where the lack of physical capacity constitutes unacceptable suffering. However, mental health is not as clear cut; with psychiatric disorders, like bipolar disorder or dementia, capacity varies over time.

One example of this can be found in the Netherlands, where a woman with dementia who was unable to speak or communicate had consented to MAID years prior through an advance directive. Aside from her husband's confirmation that these were her wishes, there was no other evidence to support the decision, and she appeared to have a generally acceptable quality of life. She appeared to be distressed while undergoing the procedure, saying right before she passed, "this is horrible".[25] It would be not contested that the woman's decision was scrutinized when she signed the advance directive, and while this is an extreme example given the woman's inability to speak, it is illustrative of the broader problem: how does someone with diminishing capacity withdraw consent from MAID?

As mentioned, a benefit of the MacArthur assessment is that it measures capacity at a point in time in a particular context, which is useful because decision-making is a spectrum.[26] The decision to end your life requires much more thought and decision-making ability than most

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[25] *Charland supra* note 17 at page 9.
[26] *Charland supra* note 17 at page 5.

other decisions. However, the question becomes where the decision to withdraw consent falls on that spectrum. Even if the woman from the Netherlands had been able to vocalize her wish to withdraw consent, would she have been deemed capable to make that decision? How much distress is required to be shown to override an advance directive?

Schizophrenia is another example. Patients with schizophrenia have delusions and are at times actively psychotic.[27] Determining capacity is complex from the start because not only do you have to consider how emotions influence decision making as discussed above, but you must also consider the shifts in emotions and potential shifts in capacity over time. It is not difficult to conceive a situation where someone has capacity and gives consent to access MAID during a period when they do not have delusions, only to subsequently wish to withdraw consent later during a psychotic episode, but is found to lack capacity to make treatment decisions on their own behalf. To follow the *Carter* train of thought,[28] if someone is logically able to consent to treatment, they can consent to MAID. The reverse must also be true; if you cannot consent to treatment, you cannot consent to MAID. However, what if you have already consented to MAID, cannot consent to treatment, and now wish to withdraw consent to MAID? Are your wishes respected or does the procedure continue?

There have been some policy solutions put forward in jurisdictions like Belgium and the Netherlands that contemplate these issues. Advance directives have been drafted, and renewal requirements have been put in place to ensure the directives are still reflective of the person's

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[27] National Library of Medicine, "Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health (2016) *Table 3.22 DSM-IV to DSM-5 Schizophrenia Comparison, online:*
<www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t22/>.
[28] *Carter supra* note 1 at para 115.

wishes.[29] However, these safeguards are only effective while the person still has capacity. They still do not address the woman from the Netherlands who outwardly displayed signs of distress. Other policy recommendations are reviewed further below.

Section 7

In a world where the Canadian Government were to prohibit MAID for those only suffering from mental disorders, it is likely that advocates launch a *Charter* challenge with respect to the prohibition. Given the near identical similarity between *Carter* and a prospective prohibition on MAID for mental disorders, section 7 would be a natural starting point. Section 7 protects the right to life, liberty, and security of the person, except in accordance with the principles of fundamental justice.[30] From the analysis in *Carter*, there is little question that a prohibition on MAID for those suffering with mental health would engage their section 7 rights. [31] The analysis will turn on whether the prohibition is in accordance with the principles of fundamental justice, each of which is examined in turn below.

Arbitrariness

For a law to not be arbitrary, there must be a rational connection between the object of the law and the limit that it imposes on life, liberty, or security of the person.[32] The analysis here would likely mirror the *Carter* arbitrary analysis. The objective of a prohibition on MAID for those

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[29] Jocelyn Downie & Georgia Lloyd-Smith, "Assisted dying for individuals with dementia: Challenges for Translating Ethical Positions into Law" (August 1, 2015) in Michael Cholbi & Jukka Vaerlius, eds New Directions in the Ethics of Assisted Suicide and Euthanasia (Springer, 2015) 97-123.
[30] Canadian Charter of Rights and Freedoms, s 7, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act (UK), 1982, c 11 [*Charter*].
[31] *Carter supra* note 1 at para 70.
[32] *Canada* (Attorney General) *v Bedford*, 2013 SCC 72 at para 111.

solely suffering from a mental disorder is to protect vulnerable people from ending their life. As found in *Carter,*[33] this is not arbitrary.

Overbreadth

As mentioned above, the overbreadth analysis focuses on the individual and whether a law is created in such a way that it captures conduct that is not connected to the objective.[34] In *Carter*, the provision against MAID was found to be overbroad because despite there being a rational connection between a complete prohibition and protecting vulnerable people, the law captured those who were not vulnerable. The analysis in *Carter* was rooted in the idea that doctors can determine capacity. Indeed, the Supreme Court rejected the argument from the Government of Canada that the provision is not overboard because it is difficult to determine vulnerability.[35] At trial, it was noted that an absolute prohibition would be appropriate if the evidence showed that doctors were unable to reliably evaluate competence.[36] While the issues with determining capacity for those suffering from mental disorders are not impossible to resolve, they are much more complex than the terminal illnesses considered in *Carter* for the reasons outlined above. However, as was noted by Dr. Donnelly at trial, depression can be reliably diagnosed and considered in a capacity assessment.[37] Moreover, because MAID is often accessed by older populations, who are prone to decline in cogitation, while cognitive impairments can be challenging to diagnose or detect,[38] it is not impossible for physicians to assess.[39]

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[33] *Carter supra* note 1 at para 84.
[34] *Ibid* at para 85.
[35] *Ibid* at para 87.
[36] *Carter v Canada* 2012 BCSC 886 at para 1364 [*Carter 2*].
[37] *Carter 2 supra* note 36 at para 790.
[38] *Ibid* at para 782.
[39] *Ibid* at para 783.

Given the ability for physicians to assess capacity, despite the issues outlined above, it would be likely that the overbreadth analysis would be similar to that in *Carter*, and the prohibition would be found to not be in accordance with the principles of fundamental justice.

Gross Disproportionality

The Supreme Court in *Carter* did not consider whether the prohibition against MAID violated the gross disproportionality principle because it was found to breach the principle of overbreadth. While it is likely the conclusion would be the same here, it is useful to consider the gross disproportionality argument briefly.

The analysis considers whether the negative effects of the law on the individual are comparable to the objectives of the law.[40] In *Carter*, this would have been the severe negative impact on the life, liberty and security of a person compared to the high importance of protecting vulnerable people.[41] Despite the high importance of protecting vulnerable people, it would likely still be found to be grossly disproportionate. To be sure, the state has a strong interest in protecting the vulnerable. However, the effects of an absolute prohibition are beyond the scope of that interest. There are ways in which the law could be tailored from a blanket ban to a more nuanced law to achieve that objective, while minimizing the negative effects of the law on an individual.

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[40] *Carter supra* note 1 at para 89.
[41] *Ibid* at para 90.

Can the Prohibition be Justified?

The prohibition would likely not be justified. The section 1 analysis would mirror the analysis seen in *Carter*. A prohibition on MAID for those only suffering from mental disorders is a pressing and substantial concern, as was found in *Carter*.[42] There is also a rational connection between the goal of protecting vulnerable groups and a complete ban.

Where the justification would likely fail is at the minimal impairment stage of the analysis. There are ways in which the government could ensure that those who are vulnerable to being coerced into requesting MAID are protected. The reliance on physicians to determine capacity and the ability to provide informed consent[43] would again be relied upon.

Safeguards

With the *Carter* decision and in light of how a potential *Charter* challenge of MAID and mental health would be decided, it would be up to parliament to put in place safeguards to protect vulnerable groups.

Present Procedure to Request MAID and Safeguards

As legislation has evolved since *Carter*, more safeguards have been put in place to protect those at risk of losing capacity. To access MAID, all patients must undergo an assessment conducted by two independent medical practitioners (either a physician or a nurse practitioner), both of which cannot have a position of authority over the patient, benefit from their death, or be connected in a way which could bias their objectivity.[44] Along with an independent witness (who

[42] *Carter supra* note 1 at para 96.
[43] *Ibid* at para 107.
[44] *Canada MAID supra* note 2 at *Eligibility.*

has similar requirements as the medical practitioners for independence), a written request for MAID must be signed by the patient and submitted. Once approved, and immediately before the procedure is to take place, the patient is given the chance to withdraw consent up until the moment the procedure begins. This occurs unless the patient signed a waiver of final consent.

Patients can waive the final consent requirement if their natural death is reasonably foreseeable, and if they waived the requirement while they still had capacity and were fully informed. A further requirement is that, in the opinion of the independent medical practitioner, the patient had a likelihood of losing capacity when they were going to end their life.[45] This exception has a further safeguard, where if the person no longer has capacity and demonstrates refusal or resistance to the procedure, consent will be deemed to be withdrawn.[46] This safeguard would likely have prevented the woman from the Netherlands discussed above from ending her life through MAID.

For patients where death is not reasonably foreseeable, the medical practitioner conducting the assessment must further explain the available treatment options to the patient requesting MAID, and a 90-day buffer between the first assessment and the administration of MAID is required. However, this buffer can be shorted if both independent medical practitioners believe the patient will lose capacity to consent to the procedure.[47]

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[45] *Canada MAID supra* note 2 at *Eligibility.*
[46] *Ibid* at *Eligibility.*
[47] Government of Canada*, Final Report of the Expert Panel on MAiD and Mental Illness* (May 2022) at page 31 [*Canada Report*].

Potential Future Safeguards

As part of the ongoing development of MAID criteria and safeguards, the Government of Canada commissioned an expert report on MAID and mental disorders.[48] The report examined ethical and methodological issues, among others, related to assessing and administering MAID for those whose only reason for requesting was mental disorder.[49] The report provided parliament with 19 recommendations.[50]

The panel recognized the issues related to capacity assessments and the exclusion of emotion in treatment decisions,[51] and provides several recommendations in response. The global recommendation is to ensure there are comprehensive capacity assessments completed. This includes the MacArthur assessment, but also includes complementary tests like the U-Doc, which takes into consideration the values of the assessor.[52] While these recommendations should be accepted and put into practice, there is still a lack of a standardized assessment tool for emotional state. As discussed above, emotion does influence how patients view and evaluate treatment decisions, and practitioners conducting assessments should be fully aware of these factors when assessing a request for MAID.

Further suggested is the use of supported decision making, a model which uses a third party to support the patient both in deciding and expressing treatment decisions.[53] It is likely that this third party would need to meet the independence requirements used for medical practitioners and

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[48] *Ibid* at page 8.
[49] *Canada Report supra* note 47 at page 9.
[50] *Ibid* at page 12.
[51] *Ibid* at page 60.
[52] *Ibid*.
[53] *Canada Report supra* note 47 at page 61.

witnesses discussed previously. However, with the concerns over capacity for individuals with mental disorders and considering the seriousness of requesting to end one's life, caution should be exercised with this model. If a patient is considered incapable of making treatment decisions, given the logic outlined in *Carter*, it should follow that they are not capable of choosing to request MAID.

Another recommendation from the panel surrounds the consistency and durability of the MAID request. Assessments should be done serially, both during symptomatic periods and in periods of remission, but not during crisis periods.[54] This recommendation addresses the issue of capacity changing over time, in addition to the issue of assessing emotion in treatment decisions. If emotional state cannot be assessed directly, repeated assessments would be an indirect measure. While this recommendation is positive, to better protect vulnerable persons it would be prudent to include a requirement for medical practitioners evaluating those who have a history of suicidal ideation or attempts to increase the 90-day waiting period. If this recommendation is being used as an indirect way to monitor emotional state over time, it is reasonable to require a longer period to ensure someone with a history of suicidal ideation is not presently in that emotional state.

Conclusion

MAID for those with mental disorders is likely here to stay. As Cory J noted in *Rodriguez,*[55] and as was reiterated by McLachlin C.J. in *Carter*,[56] the right to life necessarily comes with the right to die. The issues related to assessing capacity, like emotional state or that capacity changes over time, are of central importance to whether someone can request and be granted the right to die

[54] *Canada Report supra* note 47 at page 64.
[55] *Rodriguez v British Columbia* (Attorney General), [1993] 3 S.C.R. 519 at page 630.
[56] *Carter supra* note 1 at para 60.

with dignity. It goes to the core of bodily autonomy. These issues are also complex. The human brain and consciousness are not easily understood, particularly so when affected by mental health challenges.

The question ultimately becomes how, and in what ways, vulnerable people can be protected from being unduly pressured or coerced into ending their life. The policy recommendations above are a start, however they are not exhaustive. It has been 7 years since *Carter*. Questions linger, debates intensify, and it is only the beginning. Soon, MAID will be accessible to those only suffering from mental disorders, and it will be up to governments and medical practitioners to ensure that the right to die is treated with the utmost seriousness.

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