MAID Based on a Mental Disorder: Two Unresolved Problems for Public Policy

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In this Brief, I argue that two major problems for public policy need to be resolved before Medical Assistance in Dying (MAID) on the sole basis of a mental disorder can be safely implemented. The first problem concerns the question of how to operationalize the irremediability requirement in a way that is relevant and internally coherent. The second problem is that allowing MAID for mental disorders, while continuing to prevent suicide as a public health measure, leads to problems that jeopardize the safety of both practices. These two problems for public policy relate directly to the conceptual question –beyond the purview of these comments– about the difference between physical and mental disorders, which remains vastly undertheorized in this debate (Nicolini, 2021). Suffice it to say that, when a framework conceived for medicine is applied to mental disorders –research about the practice shows– we encounter major downstream policy problems, as outlined below.

How should we operationalize the irremediability requirement?

1. Inadequacy of the objective standard for irremediability

The irremediability requirement in Canada endorses a subjective standard for irremediability, i.e. as a function of what a patient considers acceptable. This differs from frameworks in other countries. In fact, the Netherlands and Belgium, while allowing for patients to determine what they consider reasonable, nonetheless demand that the decision be grounded in an objective standard for irremediability, in function of the patient's diagnosis and prognosis. For example, prevailing professional guidelines in these countries state that prognosis prediction and irremediability should be assessed "according to current medical understanding" and "from an objective medical-psychiatric perspective"(NVVP, 2018, VVP, 2017). In a systematic review of the professional debate about the practice (Nicolini *et al.*, 2020a), my colleagues and I found that the inability of clinicians to predict prognosis in mental disorders is the single most invoked claim. A separate analysis of the state-of-the-art evidence about prognosis prediction (Nicolini et al, *submitted*) suggests that the objective standard for irremediability is inadequate when applied to mental disorders.

2. Problem with the subjective standard for irremediability

If the objective standard for irremediability fails, this poses problems for the Benelux jurisdictions. While the public believes a key safeguard for the practice to be that specialists use their expertise to single out irremediable cases, in reality they cannot because there simply is no such thing as accurate long-term prognosis prediction in mental disorders. If then these jurisdictions opt for allowing MAID for mental disorders using a subjective standard, they will need to first work out how the irremediability requirement is to be relevant or useful. Naturally, the same question will apply to Canada. On a subjective standard, the irremediability requirement risks being conflated with the subjective unbearable suffering requirement, leaving us with two instead of three substantive requirements. If so, we need to address the question of the adequacy and sufficiency of having two requirements.

Is the combination of suicide prevention and MAID for mental disorders safe?

1. A clinical tension poses problems for the practice of MAID for mental disorders

In countries allowing MAID for mental disorders, a person can express their death wish in two ways: by requesting MAID or by engaging in suicidal behaviour. Currently, guidelines do not allow for a principled way to make a distinction between these two. The clinical marker guidelines rely on, i.e. impulsivity, is misguided: suicidal behaviour is rarely impulsive, and often carefully planned and well-thought of. How then, can a clinician ensure that a request for MAID does not stem from suicidal behaviour? This tension is corroborated by the fact that clinical profiles appear to be similar in MAID and suicidal behaviour, as evidenced by the high prevalence of women in both situations (Nicolini *et al.*, 2022). The key role of gender supports existing research showing similarities in terms of clinical profile. As a result, as things stand, it is unclear whether we can draw a firm distinction between MAID and suicidality, posing a major problem for the practice of MAID for mental disorders.

2. The clinical tension jeopardizes the safety of suicide prevention

This clinical tension also jeopardizes suicide prevention as a public health measure. First, because guidelines for MAID for mental disorders currently have no safeguards to filter out suicidal patients. For example, they are silent on how evidence-based treatments for suicidality should be built into MAID evaluations. Given that we cannot draw a firm distinction between MAID and suicidality, such safeguards are needed. Second, research indicates that suicide risk factors play a major role in MAID requests. For example, a history of gender-based violence is a well-known risk factor for suicide, is present in a significant portion of persons who receive MAID for mental disorders -mostly women (Nicolini *et al.*, 2020b). In suicide prevention, such risk factors are rigorously studied and the target for population-wide prevention strategies. We lack systematic and comparative assessment of how amenable societal suicide risk factors lead persons to request MAID. As a matter of safe suicide prevention, we need to characterize the magnitude of this empirical question.

3. The clinical tension points to a conceptual problem for public policy

The difficulty distinguishing MAID and suicidality points to a broader, unresolved conceptual problem: how do we justify treating similar patients *differently*? In other words, how do we weigh personal autonomy against the risks and benefits of the decision at stake, namely that of deliberately ending one's life? The 'risk' or outcome (i.e. death) is the same in the two situations yet, as of now, it is weighed very differently. This question poses an urgent conceptual and ethical challenge –and the basis of my current 3-year research project funded by the Belgian Research Foundation Flanders (Grant 12ZO922N). We need to examine whether we can define the standards for an informed and autonomous request to die, in a way that allows for the two practices to be compatible and safe. From a public policy and public mental health perspective, legalization of MAID for mental disorders hinges on this question.

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