Medical assistance in dying and mental illness: Perspectives from 2S/LGBTQ+ individuals in Atlantic Canada

by

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We acknowledge and respect the Lək^{w}əŋən (Songhees and Esquimalt) Peoples on whose territory the university stands, and the Lək^{w}əŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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Supervisory Committee

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Abstract

In March 2027, medical assistance in dying (MAID, also referred to as physician-assisted suicide) in Canada will be available to those with mental illness (MI) as the sole underlying condition (MAID-MI). The literature surrounding MAID-MI rarely consults individuals with MI; consequently, there is urgent need to understand this population's perspectives. A key intersecting/sub-population is 2S/LGBTQ+ (Two-Spirit, lesbian, gay, bisexual, transgender, queer) Atlantic Canadians with MI, who will be disproportionately affected by the change in MAID eligibility for several reasons. These include: 1) intersections of sexual/gender minority status with homelessness and poverty, and the impact of rising costs of living in Atlantic Canada; 2) associations between sexual/gender minority status and MI/suicidality, and the impact of barriers to accessing timely and competent healthcare in Atlantic Canada, specifically gender-affirming and mental health care; and 3) associations between homelessness, suicidality, and likelihood of seeking MAID. This study used an interpretive description methodology, informed by a feminist-of-colour disability framework, and community collaboration, and engaged 2S/LGBTQ+ Atlantic Canadians with mood disorders through qualitative one-on-one interviews to understand their perspectives on MAID-MI and how their experiences and identities impacted these perspectives. Of the 38 participants, 63% were white and the remaining 37% represented diverse races/ethnicities: Indigenous, First Nations, Métis, or Inuit; Black, East or Southeast Asian; Latino/Latina/Latine/Latinx; and South Asian. A minority (21%) identified as cisgender. A reflexive thematic analysis of the verbatim interview transcripts focused on the topic of autonomy in the context of MAID-MI within the Atlantic Canadian healthcare system. These results identify possible complications for MAID-MI implementation and highlight areas where

additional safeguards could be enacted to ensure equity for and prevent abuse of power against 2S/LGBTQ+ or other marginalized communities.

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Preface

The study discussed in this thesis was a collaboration between the University of Victoria (Dr. Nathan Lachowsky and Dr. Simon Carroll), Mount Saint Vincent University (Dr. Áine Humble), and Egale Canada (Dr. Brittany Jakubiec), and was funded by a SSHRC Partnership Engage Grant. The thesis is organized as follows. Chapter One includes a literature review, my (Jay Tang's) positionality statement, and a description of the methodology used. Chapter Two is a planned submission to the journal *Social Science and Medicine*; as it follows the publication guidelines of this journal and is intended to be a standalone publication, there is some overlap in the content covered in the other chapters. Chapter Three reports additional results, and Chapter Four contains an overall discussion and conclusion.

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Chapter 1: Introduction

Research statement

Medical assistance in dying (MAID) is a highly debated topic in fields such as medical ethics, palliative care, and psychology, with both staunch supporters and opponents. Despite the debate, the rate at which MAID is provided in Canada continues to increase year by year, as legislation has widened eligibility criteria (Fourth Annual Report, 2023). In March of 2027, eligibility for MAID will be expanded further to include those with mental illness (MI)[1] as the sole underlying condition. This expansion is controversial, and recent years have seen a drastic increase in research and publications seeking to understand and express perspectives on medical assistance in dying for MI (herein MAID-MI). Though those with MI stand to be the most significantly affected by this change in legislation, current research vastly prioritizes the voices of physicians, nurses, lawyers, ethicists, and other so-called experts over those with lived experience.

A key population for such research is 2S/LGBTQ+ (Two-Spirit, lesbian, gay, bisexual, transgender, queer) Atlantic Canadians with MI, who will be affected by the change in eligibility for several reasons. These include: 1) associations between homelessness, suicidality, and likelihood of seeking MAID, 2) intersections of sexual/gender minority status with homelessness

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[1] The term "mental illness (MI)" is nebulous and does not have a clinical definition, unlike the term "mental disorder", which is defined by the DSM-V as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or development processes underlying mental functioning" (*Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, 2017). However, I will be using the term "mental illness (MI)" throughout this thesis as it is the term used in legal documents regarding MAID-MI (e.g., Bill C-7, 2020-2021; *Criminal Code,* 1985).

and poverty, and the impact of rising costs of living in Atlantic Canada; and 3) associations between sexual/gender minority status and MI/suicidality, and the impact of barriers to accessing timely and competent healthcare in Atlantic Canada, specifically gender-affirming and mental health care. This study explores the perspectives and concerns of 2S/LGBTQ+ Atlantic Canadians with MI surrounding MAID, as well as the ways in which marginalization and relationships to power impact such perspectives.

Literature review

This literature review is divided into four sections, exploring the following topics: 1) the current ethical and clinical perspectives on MAID-MI, where "current" is defined as within the past ten years; 2) MAID-MI in the Canadian context; 3) the relevance of MAID-MI to the 2S/LGBTQ+ community; and 4) the relevance of MAID-MI in Atlantic Canada.

Part 1: Current ethical and clinical perspectives

This section is divided into three parts based on the most common areas of debate identified throughout the literature, which are irremediability, capacity, and suicidality. These are necessarily intertwined, but are distinct enough to warrant discrete arguments. For the purposes of this review, the concepts are differentiated as follows. *Irremediability* refers to the discernment of a MI, or of the suffering caused by a MI, as unable to be remedied, cured, or relieved. Experiencing irremediable suffering or having an irremediable medical condition is legal requirement for MAID-MI access in the Netherlands and Belgium[2], and will be a legal

[2] Literature produced in countries other than Canada utilize a variety of terms for MAID, including physician-assisted death, medically assisted death, euthanasia, and assisted suicide. For clarity and consistency, throughout this review I will only be using "MAID" and "MAID-MI".

requirement in Canada. *Capacity* refers to the legal decision-making ability of an individual and their ability to provide informed consent; an individual must have capacity in order to be approved for MAID-MI. *Suicidality* refers to the risk of suicide in an individual, and to the discussion of how to determine if an individual's wish to die is a symptom of their psychopathology or not. Suicidality differs from capacity, as capacity deals with overarching decision-making (including decisions on (dis)continuing treatment) while suicidality deals solely with the wish to die. In each section, I will provide a brief overview of why the topic is an area of debate, and I will highlight the main arguments proposed by those supportive of MAID-MI, and those opposed to it.

1.1 Irremediability

There is considerable debate around the specific definition of "irremediable" in the context of MI. The concept of ruling an MI to be "incurable" is a difficult one for many to grapple with, especially in the case of MI such as depression, for which treatment success is incredibly context-dependent (e.g., Elwadhi & Cohen, 2020). The debate is further complicated by the effect of social factors such as race, gender, sexuality, and socioeconomic position on both mental health and on access to treatment for MI.

As Yarascavitch (2017) and Zhong et al. (2019) note, while a treatment like chemotherapy has an objective endpoint after which further treatment is ineffective and/or dangerous, such objectivity and certainty is elusive in psychiatry. Research among physicians has exposed varying opinions on the possibility of accurately establishing irremediability in the case of a MI. A survey revealed that almost 70% of Dutch physicians believed that establishing irremediability is possible (Evenblij et al., 2019); however, qualitative interviews with psychiatrists, all of whom had experience assessing MAID-MI requests, revealed a significant

amount of doubt (Van Veen et al., 2022). One psychiatrist expressed their difficulty establishing irremediability, saying: “We all know examples of people with, for example, therapy-resistant depression, which we have more or less given up… and then a few years later you find out to your surprise that they have found their way and recovered” (Van Veen et al., 2022, p. 488). The problem, as identified by Sinyor & Schaffer (2020) in their scoping review, is the lack of clinical empirical research detailing whether or not MI can actually be irremediable, and how this can be determined.

van Veen et al. (2021) brought together a group of 67 Dutch and Belgian psychiatrists to discuss potential criteria for establishing irremediability of a MI. The group came to consensus on thirteen criteria pertaining to both diagnosis and treatment attempts. These include a requirement for structured psycho-diagnostic testing, provision of a narrative account of the history of psychiatric suffering, efforts to improve the patient’s social situation, and scrutiny of past therapeutic attempts to ensure that they were properly performed (Van Veen et al., 2021, p. 763). These criteria provide insight into how these psychiatrists assess irremediability; they are not, however, enshrined in law or in Canada’s Model Practice Standard for MAID (*Model Practice*, 2023), nor are they empirically tested for their validity. Assessments of irremediability are therefore generally left to the discretion of the physician. Clearly, there remain discrepancies, as almost one-fifth of MAID-MI cases in the Netherlands from 2011-2014 involved a disagreement between physicians regarding irremediability (S. Y. H. Kim et al., 2016). Additionally, an analysis of 48 approved MAID-MI requests in Belgium found that eight individuals withdrew their requests before the procedure occurred, inviting uncertainty as to whether or not their suffering was truly irremediable (Thienpont et al., 2015).

Much wariness and opposition to MAID-MI rests on the slippery concept of irremediability. Sinyor & Schaffer (2020) emphasize the differences between conditions that are incurable (or chronic) and conditions that are irremediable (or untreatable). They argue for the importance of this distinction, as there are many conditions that are incurable – such as asthma – but this does not necessarily equate to these conditions being irremediable or unbearable. Brodeur et al. (2022) present a similar point in their discussion of MAID-MI for individuals with borderline personality disorder, explaining that those with borderline personality disorder rarely experience full recovery, but that many reach extended periods of remission where their symptoms are manageable. Notably, the first criminal case in Belgium involving MAID-MI centred around an individual with borderline personality disorder. This individual had experienced periods of remission, but applied for MAID-MI after a series of negative life events, and was accepted despite the fact that she had at several points expressed some hesitancy about MAID-MI (De Hert et al., 2022). It remains unclear, and impossible to determine, if this patient's suffering and condition were truly irremediable or if, as with other times in her life, she may have achieved remission with further treatment.

The extent to which the measure of "irremediability" is impacted by life events or social conditions remains similarly unclear. Maung (2023), Ho and Norman (2019), Simpson (2017), and Gaind et al. (2022) all highlight the importance of considering the social determinants of mental health in assessment of MAID-MI requests. They question how physicians should proceed if an individual's suffering, or their MI, stems from their socioeconomic position, experiences of systemic or interpersonal discrimination, or effects of intergenerational trauma. Maung (2023) espouses an externalist approach to MI that encompasses the impact of social environment on one's mental health. If a patient's depression is unresponsive to treatment

because their depression is caused primarily by relentless racial discrimination in their life, should it be deemed irremediable? The aforementioned criteria for establishing irremediability (Van Veen et al., 2021) included a requirement to make "substantial efforts… to improve the patient's social situation", but there is no elaboration as to what specific efforts should be employed. Further, one's socioeconomic position – which is impacted by their race, gender, and sexuality, among other factors – will impact what treatment options they can feasibly undergo (Ho & Norman, 2019). How a physician should proceed if a patient is financially unable to undergo a potential treatment remains unexplored.

In a review of MAID-MI case reports in the Netherlands, Kim et al. (2016) discovered that information about patient's social circumstances or demographics were rarely mentioned, making it difficult to determine if factors like racial discrimination or financial insecurity contributed to the patients' suffering. To gain further insight, Verhofstadt et al. interviewed 16 patients in Belgium who had requested MAID-MI. These interviews revealed a disquieting trend: all participants had struggled financially, and when asked about things that may have prevented them from resorting to MAID-MI, many mentioned "more accessible and affordable mental healthcare" (Verhofstadt et al., 2021, p. 162). These interviews, along with the aforementioned case report analysis, also shone light on the fact that an oft-cited reason for MAID-MI requests is simply loneliness. Patients felt isolated from others, "utterly lonely" and that they were unable to maintain meaningful relationships; one report wrote that "the patient indicated that she had had a life without love and therefore had no right to exist" (Kim et al., 2016, p. 4; Verhofstadt et al., 2021). Gaind et al. (2022) question if loneliness and social suffering are truly irremediable, and if MAID-MI is truly the best option.

Schuklenk & Vathorst (2015) argue that the root of a patient's suffering is irrelevant, and that advocating for hypothetical solutions to social suffering (in place of MAID-MI) is of no use to the individual currently experiencing "irremediable" suffering. Similarly, Rooney et al. (2017) assert that it is "epistemically impossible" to be fully certain that an individual's condition is irremediable, or to know if social interventions might help, but that in the interest of reducing harm to the individual currently suffering, MAID-MI should be provided anyway. They acknowledge that when assessing requests for MAID-MI, mistakes will be made; people will die who had the possibility of recovery. However, they propose that "a small number of avoidable deaths" is justifiable in order to prevent suffering, whether that suffering stems from purely one's MI, or from social conditions (p. 330). This is challenged by Sinyor & Schaffer (2020), who question how many avoidable deaths are tolerable before the cost-benefit scale tips the other way.

The majority of this section has explored the challenges in assessing irremediability, and has mainly highlighted the arguments of MAID-MI *opponents*. In the area of irremediability, *supporters* of MAID-MI focus on what Zhong et al. (2019) describe as "qualitative" irremediability. In contrast with quantitative irremediability, which is based on clinical research and statistical probability of treatment success, qualitative irremediability depends on "the patient's subjective view about the quality of an outcome in determining when 'enough is enough'" (Zhong et al., 2019, p. 62). Because the concept of qualitative irremediability interacts more closely with a patient's autonomy and decision-making capacity, I will discuss this further in the next section.

1.2 Capacity and autonomy

The second area of concern regarding MAID-MI is the issue of capacity – determining whether or not an individual is cognitively competent to make decisions about their healthcare. Related to capacity is the concept of autonomy, a priority in the field of medical ethics, but one that is afforded to patients only if they are deemed to be capable (see Steinbock, 2017). Evaluating an individual's capacity is a crucial aspect of MAID-MI, but it is complex. Clinically, capacity evaluation is imperfect; theoretically and politically, the conversation is entangled in the history of stigmatization and mistreatment of those with MI.

Proponents of MAID-MI, such as Dembo et al. (2018) and Bahji & Delva, (2021) wield the accusation of "paternalism" liberally when discussing capacity and hesitations about MAID-MI. The field of medicine has historically stripped away the rights of those deemed mentally incompetent, and the concepts of competence and capacity have been used to justify abuse of those with MI (e.g., Szmukler, 2014). Some researchers are of the belief that even to introduce the question of capacity into the debate around MAID-MI is an expression of medical paternalism and further contributes to the stigma faced by those with MI (Bahji & Delva, 2022; Dembo et al., 2018; Hewitt, 2013; Rooney et al., 2018). Rooney et al. and Dembo et al. specifically level harsh criticism at the idea that individuals with MI are "vulnerable" and in need of protection against medical abuse; they argue that it is irrational to restrict MAID from this entire population on the basis that some of them may not be capable. Those who make such arguments do concede that some people who request MAID-MI will be incapable, and that those who are incapable should not be provided with MAID-MI. They presume, therefore, that there are few or insufficient/tolerable flaws in the process of establishing whether or not a given individual has capacity.

Commonly-accepted understandings of capacity require four criteria to be met: the patient must be able to reason, express a choice, understand information, and appreciate consequences (Schweitser et al., 2021). Whereas previously, individuals were deemed capable if they could demonstrate capacity globally (in all areas of life), current conceptualizations of capacity are "decision-specific" – relating only to the specific medical treatment in question (Charland et al., 2016). This means that an individual could be deemed incompetent to make financial decisions, but competent to make a decision about MAID-MI. There are several empirically-tested measures used to assess capacity, the most common of which is the MacArthur Competence Assessment Tool (Grisso et al., 1997), which was designed specifically to determine a patient's capacity to consent to treatment. It has been, and continues to be, extensively tested for its validity, and has been used to successfully assess capacity in patients with a variety of MI, including schizophrenia and depression (Wang et al., 2018). Charland et al. (2016) argue that despite its performance on these tests, the MacArthur Competence Assessment Tool still fails to take into account all of the aspects that impact capacity. Specifically, they name values (cultural and societal), emotions, and hope as three factors that impact decision-making capacity – especially in the context of MAID-MI – and write that "a model of decision-making that relies exclusively on cognitive abilities seems very incomplete" (p. 5).

Though flawed, the MacArthur Competence Assessment Tool remains the most thoroughly validated capacity assessment tool. Even supporters of MAID-MI, who caution against enforcing medical paternalism, advocate for proper assessment of capacity in order to avoid medical abuse (e.g., Dembo et al., 2018). However, recent studies have found that physicians rarely use empirically-tested capacity assessment tools during their MAID-MI assessments. Through qualitative interviews with physicians in Belgium, Schweitser et al. (2020)

discovered that the majority had no formal training in assessing capacity, did not know that tools such as the MacArthur Competence Assessment existed, and generally assessed capacity "in an informal way during conversations", relying on "experience and intuition" (p. 3). Similarly, in an analysis of MAID-MI case reports in the Netherlands, 92% failed to reference all four criteria for decision-specific capacity; less than half even assessed decision-specific capacity (Doernberg et al., 2016). In both cases, physicians placed disproportionate emphasis on the patients' ability to make a choice, while neglecting to assess the other three criteria. Evidently, failing to utilize standardized assessment tools introduces a greater degree of subjectivity to capacity assessment. To remedy this, Zhong et al. (2019) propose that capacity assessment should be completed by an objective third party (other than the MAID-MI assessing physician); specifically, they suggest that forensic evaluators should be utilized. This, however, remains simply a suggestion, and capacity evaluation remains substandard.

If an individual is deemed to be capable, correctly or incorrectly, they have the right and autonomy to make decisions about their medical treatment. This fundamentally includes refusal of care. It is in this context that capacity and autonomy become implicated in assessment of irremediability – as Steinbock (2017) writes, "in the case of competent patients, autonomy trumps well-being" (p. 34). As earlier noted, MAID-MI proponents advocate for an understanding of irremediability that rests on the decision of the individual patient, that is, when the patient themselves deems further treatment unacceptable. This introduces a struggle: if a patient is able to refuse treatment, and irremediability is based on a patient's treatment refusal, then empirical/clinical constructs of irremediability become irrelevant, because it is fully dependent on a patient's decision (Yarascavitch, 2017). In other words, an individual with a treatable condition could refuse treatment, therefore establishing (qualitative) irremediability,

and be eligible for MAID-MI. However, this reopens the question of whether or not that individual is competent; would a competent individual refuse a treatment that is likely to succeed? Further, some argue that to even introduce the option of MAID-MI into the realm of psychiatric treatment could alter a patient's willingness to attempt different treatments, as their end goal may shift from recovery to MAID-MI (Simpson, 2018; Yarascavitch, 2017).

Individuals have the right to refuse care; that is an issue of bodily autonomy. Some proponents of MAID-MI seem to conflate this right to bodily autonomy with a right to receive MAID-MI, but this is, from a legal standpoint, inaccurate (Steinbock, 2017). In other words, the Charter protects individuals' right to make decisions about their life and bodily autonomy, and this includes the right to choose to die. Suicide, therefore, is not illegal in Canada; "the right to life does not give rise to a duty to live" (*Section 7 - Life, Liberty and Security of the Person*, 2023), and people are free to end their life if they so choose. However, Canadians are not entitled to be *aided* in their death. In fact, to aid a person in suicide is a crime in Canada; Simpson (2017) points out that "suicide must be the only legal act that is illegal to assist" (p. 82). Evidently, MAID for physical illness is exempt from this law, but the introduction of MAID-MI complicates this exemption, as suicidality is often associated with or exacerbated by MI (e.g., Hoertel et al., 2015). If aiding in suicide is illegal, but assisting someone to die by MAID-MI is legal, it stands to reason that we must draw a distinct line between a desire to die by MAID-MI and a desire to die by suicide. This leads to the third area of debate: the relationship between suicide and MAID-MI.

1.3 Suicidality

How does one reconcile the goal of suicide prevention with the provision of MAID-MI? If a psychiatrist is approached by a patient who wants to end their life, how should they decide

between mobilizing suicide prevention strategies and offering MAID-MI? Alternatively, is it even important to distinguish between those who want MAID-MI and those who are suicidal – if someone wants to die, should their death be facilitated no matter the reason? These questions are fundamental to the MAID-MI debate and pose, according to Kious & Battin (2019), a "moral crisis". They argue that current laws regarding the involuntary commitment of suicidal persons cannot meaningfully co-exist with laws allowing the provision of MAID-MI, because the moral beliefs underlying each of these laws are fundamentally incompatible. Perspectives on the relationship between suicidality and MAID-MI are divided, and will be explored in this section.

Some proponents of MAID-MI adamantly propose a distinction between suicide and MAID-MI, and believe that health care providers can simultaneously support the endeavors of both suicide prevention and MAID-MI without contradicting themselves. A group of Dutch psychiatrists and general practitioners expressed that suicidality was impulsive, related to acute psychological distress or influenced by a troubling occurrence in the individual's life, and an aspect of the individual's psychopathology (Pronk, Willems, et al., 2021). These physicians described suicidal individuals as "ambivalent until the end" (p. 276), and many felt capable of differentiating suicidal ideation from a reasonable MAID-MI request (Evenblij et al., 2019). These sentiments were echoed by mental health care providers in Québec, who characterised suicide as an impulsive and irrational response to an impermanent state of suffering (Montreuil et al., 2020). In contrast, those who request MAID-MI were portrayed as having thoughtfully, and continually, appraised the reality of their life and their future in order to come to the conclusion that they wished to die (Bahji & Delva, 2022; Hewitt, 2013; Montreuil et al., 2020; Pronk, Willems, et al., 2021). Den Hartogh (2016) argues that, using the definition of the word, suicide

and MAID-MI are both suicide, but denotes MAID-MI as "rational" suicide, while others are "irrational".

The concept of rational suicide is not novel to the MAID-MI conversation; the literature defines a rational suicide as one that occurs when the individual has a realistic appraisal of their future and is not in acute psychological distress, and when the decision to die would be deemed reasonable by most others (Hewitt, 2013). It is evident that, intentionally or not, most distinctions made between suicide and MAID-MI are rooted in the perceived dichotomy between rational and irrational suicide. This is further exemplified by Health Canada's expert report on MAID-MI, which indicates that a reasonable request for MAID must be consistent, durable, and well-considered, and not made during a period of crisis (Final Report, 2022). But what is the process of judging whether or not a request is well-considered, or whether an individual's appraisal of their future is realistic? This often comes down to the third criteria for a rational suicide – that the decision to die would be deemed reasonable by most others – and in many cases, the "most others" in question consists solely of the assessing physician(s). Indeed, Dutch physicians have acknowledged that a central factor in their approval (or denial) of a MAID-MI request is whether or not they can empathize with the requestor's desire to die (Pronk et al., 2021). This means, evidently, that a person's access to MAID-MI hinges largely on a physician's subjective judgment on the amount of suffering that warrants a "reasonable" wish to die.

MAID-MI opponents contest physicians' ability to accurately, consistently, and equitably distinguish between suicidality and a "reasonable" request for MAID, and identify flaws in the commonly-stated differences between the two. Though "impulsivity" is often put forward as a fundamental characteristic of suicide (e.g., Bahji & Delva, 2022; Pronk et al., 2021; Pronk, Willems, et al., 2021), it appears to be a scientifically unfounded claim. Research has shown that

impulsivity is not a key predictor of suicide (e.g., Klonsky & May, 2010); additionally, the vast majority of validated suicide risk assessment tools include at least some measure of planning and of duration of suicidal ideation, with higher planning and longer-lasting ideation indicating greater risk (e.g., Alphs et al., 2020; Lindenmayer et al., 2003; Posner et al., 2011). Kious & Battin (2019) note that "in practice, the more considered or premeditated [a patient's] plan for suicide, the more likely she is to receive an involuntary commitment in order to prevent her suicide" (p. 35). The fact that involuntary commitment becomes more plausible if an individual has been consistently suicidal conflicts with the idea that all suicidal thoughts are fleeting and only MAID-MI requests are longstanding and well-considered.

While some concern themselves with debating the differences between suicide and MAID-MI, others argue that suicidality sometimes manifests as a request for MAID-MI, but that suicidal persons should not necessarily be excluded from MAID-MI. These arguments portray MAID-MI as a form of harm reduction and, seemingly counterintuitively, a form of suicide prevention (where suicide is distinguished from MAID-MI solely by the way that the death occurs). Interviews with individuals who had requested MAID-MI and with relatives of those who died by MAID-MI revealed similar attitudes. Relatives were grateful for the opportunity to say goodbye to their loved ones and to witness their dignified death; requesters of MAID-MI sought the "open[ness] and honest[y]" that came with a death by MAID-MI, as well as the knowledge that their loved ones would not face the trauma of finding their body (Pronk et al., 2022, 2023; Verhofstadt et al., 2021). In a survey of Dutch physicians, only one quarter indicated that they were unsupportive of utilizing MAID-MI as a suicide prevention measure; in contrast, nearly two-thirds of these respondents believed that "providing assistance with suicide is compatible with a care provider relationship" (Evenblij et al., 2019, p. 4). The idea of MAID-MI

as harm reduction reflects the belief that if a suicidal person really wants to die, they will find a way to do so. Therefore, providing MAID-MI prevents that person from resorting to a potentially violent death that may be traumatizing for those around them, and offers instead what is often perceived as a more peaceful death (e.g., Wiebe & Mullin, 2023).

However, some researchers challenge the idea that suicidal persons who are denied MAID-MI would simply find another way. Through an analysis of MAID-MI statistics from the Netherlands, Nicolini et al. (2021) propose that MAID-MI is providing death to a group of people who would otherwise not die by suicide. In the Netherlands and Belgium, the ratio of women to men who have died by MAID-MI ranges from 2.3:1 (S. Y. H. Kim et al., 2016) to 3.3:1 (Dierickx et al., 2017). Rather than reflecting gender distributions of non-MAID suicides in these countries, these ratios mirror those of suicide *attempts*. Nicolini et al. (2021) note that women generally attempt suicide with less lethal and less violent methods, which is why more women attempt suicide but more men die by suicide. They suggest that this represents lower suicide capability, which requires "the ability to face death and to enact something painful to one's own body" (p. 3). Because MAID-MI is painless, one no longer needs to perform a painful self-injurious act in order to die; the provision of MAID-MI is therefore removing a barrier to suicide that kept many people, mainly women, alive (Nicolini et al., 2022). Gaind et al. (2022) similarly interpret the gender distribution of MAID-MI, arguing that MAID-MI "risks converting transient suicidality in some to a permanent death" (p. 76).

Evidently, the differences between suicidality, suicide, and MAID-MI are complex, and the discussion of whether the differences even matter is similarly intricate. Suicidality as an issue in the context of MAID-MI, along with capacity and irremediability, remains unresolved as Canada continues to move forward to the legalization of MAID-MI.

Part 2: MAID-MI in the Canadian context

The legalization of MAID (for terminal physical illnesses) in Canada was prompted largely by the Supreme Court case *Carter v. Canada*. The plaintiffs argued that the ban on MAID infringed on *Charter*-protected rights; the Supreme Court unanimously agreed. The Supreme Court found that the ban violated the right to life by "forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable" (*Carter v. Canada*, 2015). Additionally, the rights to liberty and security of the person were ruled to be violated, as the ban "[denied] people in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenches on their liberty… by leaving them to endure intolerable suffering, it impinges on their security of the person" (*Carter v. Canada*, 2015*)*. The ruling was swiftly followed by the passing of Bill C-14 in June 2016, which modified the Criminal Code to legalize MAID and detailed eligibility criteria. At the time, in order to be eligible to request MAID, an individual was required to have a "grievous and irremediable medical condition", and their natural death needed to be "reasonably foreseeable", among other requirements.

As earlier noted, MAID-MI will become legal in Canada on March 17, 2024, as a "sunset clause" of Bill C-7. Bill C-7 was enacted in Canada on March 17, 2021 in response to a case from the Superior Court of Québec, where it was ruled that the requirement that a person's natural death be reasonably foreseeable infringed on the *Charter*-protected rights to equality, life, liberty, and security of the person. The bill did the following: 1) repealed the requirement that natural death must be reasonably foreseeable in order to be eligible for MAID, 2) established that MI *does not* qualify as a grievous or irremediable medical condition for the purposes of MAID eligibility, and 3) added a provision that the disqualification of MI would be automatically

repealed two years following the passing of Bill C-7 (Nicol & Tiedemann, 2021). The two-year waiting period for MAID-MI was extended for an extra year in February of 2023, and was subsequently extended for an extra three years in February of 2024, reportedly due to the unpreparedness of the healthcare system to safely and equitably implement MAID-MI (Government of Canada, 2024).

An additional provision in Bill C-7 required an independent review to be conducted by experts regarding MAID-MI. Importantly, this review was not to debate the legalization of MAID-MI, but rather to provide perspective on additional protocols and safeguards that could be put in place to carry out this change safely (Final Report, 2022). The report provided 19 recommendations, but significantly did not recommend that any additional legislative safeguards specific to MAID-MI be added to the Criminal Code, instead insisting on the adequacy of existing safeguards, "so long as those are interpreted appropriately to take into consideration the specificity of mental disorders" (Final Report, 2022, p. 50). The majority of the report highlighted expert viewpoints on several major areas of concern regarding MAID-MI, three of which are the aforementioned irremediability, capacity, and suicidality. This section will situate the MAID-MI debate specifically in the Canadian context, drawing on the MAID-MI expert report, the Criminal Code, and ethical and clinical discussions.

A person must have a "grievous and irremediable medical condition" in order to be eligible for MAID, and this will not change in the case of MAID-MI. The definition of a "grievous and irremediable medical condition" is expanded upon in section 241.2(2) of the Criminal Code, which states that an individual must be in an "advanced state of irreversible decline" due to a "serious and incurable illness", which causes "enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions

that they consider acceptable" (Bill C-14, 2016). Opponents of MAID-MI have pointed out that the terms "incurable" and "irreversible" as they are used in the Criminal Code are not clinical terms in the assessment of MI, and are therefore left to interpretation by individual psychiatrists and physicians (Final Report, 2022, p. 40). On the other hand, MAID-MI supporters focus specifically on the phrase "suffering that is intolerable *to them* and that cannot be relieved under conditions that *they consider acceptable* [emphasis added]" – prioritizing the earlier-discussed concept of qualitative irremediability. In order to most accurately assess irremediability, the expert report recommends that at least one of the MAID-MI assessors be a psychiatrist with expertise in the patient's condition; Freeland et al. (2022), in a report from the Canadian Psychiatric Association, raise the concern that psychiatrists are in short supply in Canada, and designating psychiatrists to assess MAID-MI requests may exacerbate already long wait times for psychiatric care.

Regarding capacity, the expert report noted that issues of assessing capacity are not unique to cases of MAID-MI, and these issues "are not resolved by refusing to permit access to the intervention to all persons or a subgroup of persons" (Final Report, 2022, p. 42). The report does not offer guidelines on how capacity is to be assessed in situations of MAID-MI, again trusting the judgement of individuals physicians. Yarascavitch (2017) questions whether this trust is warranted, and highlights the conspicuous lack of capacity assessment training that general practitioners receive, despite being the healthcare providers who most often assess MAID requests in Canada. Gaind et al. (2022) express their concern over provincial laws that could require physicians to refer patients to another physician for MAID-MI requests even if they do not think criteria is met; they point to numerous cases in the Netherlands where patients

were denied MAID-MI because their physician did not think they met the criteria, but simply went to another physician who approved them (S. Y. H. Kim et al., 2016).

Further, the expert report did not provide definitive guidance on how to distinguish someone who is "rationally" requesting MAID and someone who is suicidal. The eighth recommendation of the expert panel is the one which most closely relates to suicidality; it notes the responsibility of the assessor to ensure that the request is not made during a period of crisis and is consistent, durable, and well-considered (Final Report, 2022, p. 64). The report asserts that during MAID-MI requests, physicians should carry out the "usual clinical approach" to assessing suicidality, and may proceed with involuntary commitment if deemed necessary. However, it then goes on to declare that "society is making an ethical choice to enable certain people to receive MAID… regardless of whether MAID and suicide are considered to be distinct or not" (p. 65). This, as Gaind et al. (2022) argue, is contradictory and unclear guidance on the relationship between suicidality and MAID-MI. Simpson et al. (2022) further probe the issue in their discussion of Canadian prison populations, who will be entitled to MAID-MI access, and who harbor very high rates of suicide.

As I have demonstrated, there are abundant critiques of the content of the government-commissioned expert report on MAID-MI; I have refrained from highlighting MAID-MI-supportive arguments as they largely align with the content of the expert report. It is also important to note the criticisms that have been levelled against the process of creating this report, during which two members of the committee (a bioethicist and a community advocate) resigned, citing concerns about the integrity of the committee and their motives (Gaind et al., 2022). Recently, almost one-third of the 150 witnesses called by the committee signed a public letter

denouncing the report, attesting that the committee "misconstrues, misrepresents, minimizes, and completely ignores key evidence necessary to protect Canadians" (Anderssen, 2023).

Indeed, while the expert report claims to represent the interests and perspectives of Canadian society, Gaind et al. (2022) question who, exactly, the panel represents. A survey of nearly 500 Canadian mental health care providers found that only 21.9% supported MAID-MI, though 78.6% supported MAID for terminal physical illnesses. Further, 86.2% did not feel that they were adequately prepared to address issues surrounding MAID-MI (Montreuil et al., 2020). Similar findings were obtained in a national survey of Canadian psychiatrists, with a majority supporting MAID for physical illnesses, but not for MI (Rousseau et al., 2017). Gaind et al. (2022) and Sinyor & Schaffer (2020) criticize the MAID-MI debate as being politically motivated and irresponsibly made exempt from the "usual scientific evidentiary standards" that all medical interventions should be subject to (Sinyor & Schaffer, 2020, p. 608).

Further, some individuals challenge the legal basis on which MAID-MI rests. Simpson, the Chair in Forensic Psychiatry at the University of Toronto, notes that in *Carter v. Canada*, the Supreme Court granted access to MAID (for terminal physical illnesses) because a ban on MAID had "the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable" (*Carter v. Canada*, 2015*)*. In essence, liberty protects the right to die; if someone becomes physically unable to die by their own hand, they are entitled to receive assistance. This, Simpson argues, does not apply to situations of MAID-MI where individuals remain physically capable to die by suicide. While some assert that restricting MAID-MI effectively forces people to "resort to gruesome suicide methods" (Dembo et al., 2018, p. 454), the *Charter*-protected right to liberty does not entitle one to receive assistance in dying if they are physically able to take

their own life, by gruesome means or not (Simpson, 2018). This claim appears to remain unchallenged and largely unacknowledged by MAID-MI proponents and by the expert report.

Though three years have passed since Bill C-7, there has been little success in unravelling and resolving the ethical, legal, and clinical debate around MAID-MI in Canada. The further three-year delay in legalizing MAID-MI is intended to provide the time needed to ensure MAID-MI is provided safely and equitably; how and if this will be accomplished, and who will be implicated in this ambitious task, remains to be answered.

Part 3: Relevance to 2S/LGBTQ+ community

The legalization of MAID-MI is likely to have a disproportionate impact on 2S/LGBTQ+ individuals for several reasons, which will be explored in this section. The first reason is simple: 2S/LGBTQ+ individuals are at higher risk of having a MI, experiencing suicidal ideation, and attempting suicide than their cisgender heterosexual counterparts (Bolderston & Ralph, 2016; King et al., 2008). As previously noted, the recommendation from Health Canada's expert panel for distinguishing a "rational" request for MAID from suicidal ideation is for the assessor to ensure that the request for MAID is consistent, durable, and well-considered, and not made during a period of crisis (Final Report, 2022). This recommendation is closely aligned with the literature's definition of "rational suicide"; it may unintentionally denote many 2S/LGBTQ+ suicides as "rational".

In their unique study, Clark et al. (2022) spoke with 2S/LGBTQ+ survivors of near-fatal suicide attempts to gain further understanding of the factors that influenced their decision. Almost all of the adult participants had experienced suicidal ideation since at least early adolescence, with some having had suicidal thoughts since childhood; they further reported being immersed in communities where suicidality was pervasive and persistent (p.4-5). Their

desire to die stemmed often from enduring stigma and discrimination consistently throughout their life, both interpersonally, from individuals in their lives, and structurally, through discriminatory laws and policies (p.5). Additionally, seeing older 2S/LGBTQ+ community members continuing to experience that same discrimination contributed to feelings of hopelessness about the future, and "positioned suicide as a kind of reprieve" from their suffering (p.6). These individuals experienced a "consistent and durable" desire to die outside of impulsivity in times of crisis, and "capably appraised their situation", assessing their future based on experiences of structural discrimination that are unlikely to change quickly. If these individuals were to request MAID, would their requests be deemed acceptable and rational?

A second factor is the prevalence of homelessness and poverty in the 2S/LGBTQ+ community. A 2019 study by Badgett et al. reported that the poverty rate for LGBT individuals (21.6%) was higher than that for non-LGBT individuals (15.7%), with both numbers exceeded by the poverty rate for transgender individuals (29.4%). 2S/LGBTQ+ youth in particular are overrepresented among populations of homeless individuals, resulting often from being forced out of their homes due to their sexuality or gender identity (Romero et al., 2020). For 2S/LGBTQ+ individuals, the experience of being homeless and trying to obtain financial security and housing is further complicated by anti-2S/LGBTQ+ discrimination in job markets, lack of financial and/or emotional support from family members, and lack of safety in shelters and other shared housing environments (Wilson et al., 2020). Studies have found that depression is more common among homeless LGBTQ individuals than among non-LGBTQ homeless individuals; homelessness in 2S/LGBTQ+ individuals is further associated with "greater hopelessness, depression, PTSD… lifetime suicide attempt[s] and [endorsement of] future suicide as likely" (Rhoades et al., 2018, p. 649).

In cases where an individual who is lacking adequate supports and resources requests MAID, the question is whether or not that individual would choose MAID if they were provided with such supports. Section 241.2(3.1)(g) of the Criminal Code states that the MAID assessor must:

> ensure that the person has been informed of the means available to relieve their suffering, including, where appropriate, counselling services, mental health and disability support services, community services and palliative care and has been offered consultations with relevant professionals who provide those services or that care. (Bill C-7, 2021)

The expert report recommends that housing and income support should be included in this provision, and should therefore be offered by MAID assessors during the assessment process to ensure that the MAID request is not based in the experience of structural vulnerability that could be eliminated with supports (Final Report, 2022, p. 62).

While the offering of "means available to relieve suffering" is currently mandated by legislation, media has been rapidly uncovering recent cases in which this was grossly ineffective. Since July 2022, multiple stories have been highlighted of individuals who qualified for and chose MAID, and who would not have done so if they had stable housing and finances (Alberga, 2022a, 2022b; Favaro, 2022; Mulligan & Bond, 2022; Phillips, 2022). Thirty-two-year-old Denise, for example, struggled to find housing due to her disability which caused sensitivity to common chemicals, and due to her limited income on Ontario's Disability Support Program. Amir Farsoud "[didn't] want to die", but chose death over the imminent homelessness he was forced into from the inadequacy of disability support (Mulligan & Bond, 2022). Tracey Thompson, a former chef who found "a lot of joy in life", referred to her decision to seek MAID as "exclusively a financial consideration" (Alberga, 2022a). Further, internal seminars held by

the Canadian Association of MAID Assessors and Providers (CAMAP) – the association funded by Health Canada to develop a national MAID curriculum – reveal that MAID providers acknowledge and readily accept the fact that inability to access housing, support, and/or adequate treatment has driven and will drive disabled individuals to choose MAID. MAID is not withheld from such individuals (Raikin, 2022). These cases are demonstrative of the fact that section 241.2(3.1)(g) is ineffective in preventing socioeconomic challenges from being the prime reason for an individual's MAID request. Consideration must be given to continued safeguard failure once eligibility is expanded, and to what populations such failures will impact most heavily.

The third and final influencing factor that will be discussed in this section is the effect of anti-2S/LGBTQ+ discrimination in healthcare. Research has consistently documented the discrimination that 2S/LGBTQ+ individuals face, both when receiving general medical care or when attempting to get care for 2S/LGBTQ+-specific issues, specifically gender-affirming care. For instance, research conducted in Nova Scotia found that 70% of transgender/non-binary (TNB) individuals surveyed had a negative experience with a healthcare provider, and one transgender individual expressed that they felt they were simply "surviving the healthcare system" (Gahagan & Colpitts, 2017; Middleton & Gahagan, 2022, p. 60). Discriminatory experiences in healthcare can be directly harmful to 2S/LGBTQ+ individuals, and have additionally been shown to lead to healthcare avoidance (Reisner et al., 2015). Furthermore, fear of discrimination prevents some TNB individuals from disclosing their identity to their healthcare provider, decreasing the quality and accuracy of care that they receive (Middleton & Gahagan, 2022).

The negative experiences of 2S/LGBTQ+ individuals in the healthcare system may impact MAID-MI in several ways, aside from the impact of discrimination on mental health and

suicidality in general. First, one of the requirements of having a "grievous and irremediable medical condition" is that the suffering caused by the condition "cannot be relieved under conditions [the patient] consider[s] acceptable" (Bill C-14, 2016). If an individual has continually experienced discrimination in attempting to access treatment, they may be less likely to deem further treatment "acceptable". Similarly, one of the mandated safeguards is that both the requester and the assessor are in agreeance that the requester has given "serious consideration" to means available to relieve suffering. This, again, becomes less meaningful if the means offered consist of further treatments attempts in a system that has already harmed the individual. Finally, the pervasiveness of anti-2S/LGBTQ+ discrimination in healthcare indicates that there is a lack of understanding and acceptance of 2S/LGBTQ+ people in the field. Simpson (2017) suggests that in giving MAID assessors the power to judge aspects of a MAID-MI cases, such as incurability of the MI and suicidality, we are asking them to make "individual value judgments… about which lives are worth living and which are not" (p.82). The question must be raised as to whether MAID-MI requests by 2S/LGBTQ+ individuals will be disproportionately accepted due to assessors' biases.

Part 4: Relevance in Atlantic Canada

The Atlantic Canadian region is located on the east coast of Canada and includes the provinces of New Brunswick (NB), Nova Scotia (NS), Prince Edward Island (PEI), and Newfoundland and Labrador (NL). Of the Canadian provinces, the Atlantic provinces are the smallest both geographically and by population, and the region is known for its rapidly aging population (Smellie, 2022) and its low rates of racial diversity (The Canadian Census: A Rich Portrait of the Country's Religious and Ethnocultural Diversity, 2022) in comparison with other Canadian provinces. All four Atlantic provinces have higher proportions of individuals living in

rural areas than the Canadian average (Population Growth, 2022). It is a rarely studied region in the country, and the health of Atlantic Canadians is poorly understood, though the dismal state of healthcare combined with high poverty rates make for a troubling combination.

Consistent with the rest of Canada, rates of MAID provision have increased yearly in the Atlantic provinces, with NL in particular experiencing a 38.5% increase in MAID provisions between 2021 and 2022 (Fourth Annual Report, 2023). In respect to the upcoming legalization of MAID-MI, issues of social and structural vulnerability may be particularly applicable in the Atlantic region. Along with astronomical rent increases causing high rates of homelessness and poverty (King & Cooke, 2024), the region is also experiencing a healthcare crisis. Data from Statistics Canada named PEI as the province with the worst access to regular health care providers (Brun, 2024); a recent survey found that 87% of Atlantic Canadians "worry they won't be able to access the health care they need" (Osman, 2024). Wait times to access care are long and only increasing, particularly for gender-affirming care and mental health care; trauma survivors in crisis suffer for months without mental health care (Ryan, 2022), and individuals are waiting "years" for assessment for gender-affirming care (Armstrong, 2022). Further, the healthcare systems in PEI and NL are unequipped to perform most gender-affirming surgeries, and individuals are required to travel for surgery and pay for travel expenses out of pocket (*GCS Approval Request Form*, 2023; Rollmann, 2022). For those who are able to access care, anti-2S/LGBTQ+ discrimination in Atlantic Canada is common (e.g., (Middleton & Gahagan, 2022). Inability to access care, along with prior experiences of discrimination in healthcare, may exacerbate mental health issues and increase hopelessness, a trait closely related to suicidality (Clark et al., 2022; Hirsch et al., 2017). Consideration is rarely given to Atlantic Canadians, and specifically 2S/LGBTQ+ Atlantic Canadians, in the realms of research or federal policy-making.

However, the creation of policy that is equitable to all Canadians necessitates the consultation of this population.

Part 5: Conclusion and the Current Study

The MAID-MI debate has also shown itself to be interdisciplinary, and has incited input from philosophers, physicians, nurses, lawyers, ethicists, and other academics. Conspicuously absent from the debate are the voices of individuals with MI, who form the population who will be most tangibly impacted by the legalization of MAID-MI. With the exception of one study from the Netherlands (Pronk et al., (2021b), who interviewed individuals with MI who applied for MAID-MI), and one study from Ontario (Bastidas-Bilbao et al., 2023) research has neglected to explore the opinions of people with MI, perhaps reinforcing the paternalism and stigmatization of such populations that MAID-MI supporters so staunchly condemn. A recent qualitative thematic review of literature on MAID-MI similarly notes the absence of such research and emphasizes the importance of conducting research that prioritizes the perspectives of people with MI (Favron-Godbout & Racine, 2023). Additionally, no studies have investigated the specific perspectives on MAID-MI of those in marginalized (2S/LGBTQ+, racialized, low-income, etc.) communities, where rates of MI are disproportionately high. There is an urgent need to a) explore and elevate the perspectives of diversely marginalized people with MI, and b) scrutinize why these voices have been excluded from the conversation. Until this happens, the MAID-MI debate will remain fundamentally inexhaustive.

This study explored the opinions of 2S/LGBTQ+ Atlantic Canadians on the expansion of MAID eligibility to include MI, and the influence of marginalization on these perspectives. The specific objectives were as follows:

1) Explore the perspectives of 2S/LGBTQ+ individuals living in Atlantic Canada with MI on MAID-MI;
2) Examine how experiences of marginalization and conceptualizations of self impact perspectives on MAID-MI for 2S/LGBTQ+ individuals living in Atlantic Canada with MI;
3) Identify ways in which Canadian policy on and regional implementation of MAID-MI could be changed to align with the needs of 2S/LGBTQ+ individuals living in Atlantic Canada with MI.

Researcher positionality

From this project's conception, I knew that striving for the elusive scientific "objectivity" would be futile. It has never been a secret that all my experiences and all my identities are inextricably woven into this project; the community in which I have located my research is so specifically my own, and the topic I have chosen to study carries significant emotional weight. Research is inherently shaped by those who conduct it, and it is my intention in this statement to make clear who I am.

My name is Jay, and my pronouns are they/them. I am a queer, trans, disabled second-generation immigrant; I was born as the daughter of a Chinese father and a white settler mother. My father grew up in Vietnam and came to Canada as a refugee in the era of the boat people. Though I am mixed-race, I am treated almost exclusively as Asian and as a racialized person in Canada. This was particularly true growing up on the East Coast, where I was one of very few racialized students at school in semi-rural Epekwitk (Prince Edward Island). We did not talk about race in our household, but I understood that my father was, in the dialect of Prince Edward Islanders, "From Away", and that meant that some people thought I was "From Away" as well.

My experiences growing up on PEI, and later attending university in Halifax, were largely dominated by the inescapable presence and ignorance of whiteness and by the constant acute awareness of myself as Other.

Despite this, I recognize that my proximity to whiteness affords me a level of privilege that other people of colour, specifically Black people, are not granted. I have enjoyed the benefits of being a Canadian citizen and of speaking without a "foreign" accent, two privileges I have always been aware of because of my father; I have seen how racism is compounded when one does not "sound Canadian". The impacts of colonization and displacement have shaped and disrupted the lives of my father's family significantly, creating trauma and erasing relationships to culture, land, and people. However, I have also benefited from settler colonialism as an uninvited guest for many years in Mi'kma'ki, the unceded territory of the Mi'kmaq people, and now on the unceded territory of the lək̓ʷəŋən, Songhees, Esquimalt, and W̱SÁNEĆ peoples. I benefit also from being perceived as able-bodied; as someone whose disabilities are relatively "invisible", my experiences with ableism have not included significant physical access barriers or the types of explicit discrimination experienced by those who are regularly perceived as disabled.

These identities inform how I have occupied (and continue to occupy) space within queer and trans communities in Atlantic Canada, once I felt safe enough to explore those parts of myself. These identities also shaped my struggles in accessing healthcare, specifically mental healthcare, while living in Atlantic Canada. Though I am no longer physically located in Atlantic Canada, it has always been my intention to conduct research that benefits my community there, who I love and care for deeply.

While I cannot divorce any of my identities or experiences from my research, the aspect of myself that is most deeply embedded in this particular project is my tenuous relationship with life and death. I learned about MAID-MI in October of 2022 through a news article, and I began researching MAID-MI as a way to sort through my complex feelings about it.

Geographers Ellen Kohl and Priscilla McCutcheon discuss the significance of "kitchen table reflexivity", proposing that critical reflexivity and engagement with positionalities often occur through informal conversations and everyday talk. Indeed, the way that I engaged with this project, as a researcher with lived experience and shared identities, was heavily influenced by discussions with those at my "kitchen table". Informal conversations with my community pushed me to critically examine my motivations for this project and what I hoped to accomplish. I am so grateful to everyone in my community who entertained me as I waded through the messiness of my relationship to this project.

I knew myself as suicidal long before the word entered my vocabulary; I was twelve years old the first time I remember consciously having the serious desire to die. Having grown up in a Christian household where MI and suicide were not topics of open discussion, much like my queerness and transness, for many years I buried my suicidality deep within me under layers of fear and shame. I understood it as a personal flaw and a weakness. While my suicidality initially stemmed from a need to escape my circumstances, it has followed me relentlessly out of my hometown, across the country, through top surgery, HRT – through every change for the past 12 years, I have been accompanied by suicidality that has manifested along the spectrum of severity from simple apathy towards my own life to overwhelming desire and impulse to end it. I know this part of myself well, and because of that, I know that if MAID-MI had been an option for me after I turned 18, I simply would not be alive to write this.

As I immersed myself in the laws and debates around MAID-MI, I was shocked to find, in published academic articles, the same views about suicide, death, and what lives are worth living that I had held years earlier as a young queer person overwhelmed by hopelessness. I was frustrated and angered by the perspectives absent from the literature: namely, the lack of representation of suicidal people, and specifically multiply marginalized suicidal people. For all of the research about rates of MI and suicide in queer and trans communities, we have been denied input on legislation which impacts us tangibly and will directly culminate in the deaths of community members. In a political climate that propagates hopelessness, oppresses us, and devalues our lives, I worry about my community and the impact that MAID-MI could have. I am in community with too many people with a fragile will to stay alive. I started this project because my community – specifically my queer and trans community in Atlantic Canada, with all of our unique struggles and strengths – is often forgotten, but my community matters.

My motivations for this project stemmed from my personal experiences and my care for my community, but were not theoretically grounded until I began to engage in disability justice work. I am indebted to the many disability justice activists and scholars whose knowledge, labour, and activism changed my understanding of myself and my suicidality, and shaped this project to become what it is. Learning about disability justice challenged me on many levels to work on deconstructing my internalized sanism, ableism, and shame, and gave me an intersectional framework within which I could situate my experiences in a way that felt authentic. I spent a long time thinking that to be able to conduct this research, I needed to bracket out my suicidality; I now know that I am able to conduct this research *because* of my suicidality. I therefore approach this research, and the topic of MAID-MI in general, from the perspective of someone who wants to die, and has wanted to die for a long time. Further, I approach this

research with the knowledge that the systems of oppression that impact every aspect of my life also exacerbate my want to die, and that as a queer, trans, racialized, disabled person, those systems of oppression want me, and my communities, to die.

I have situated this project within a feminist-of-colour disability framework, developed by queer women of colour Sami Schalk and Jina B. Kim. In May 2024, Sami Schalk was assaulted by police while protesting in solidarity with the student encampment for a free Palestine at the University of Wisconsin-Madison. To be silent about genocide is to be complicit, and it has become, in recent months, increasingly apparent that academia is a field ripe for complicity. Research has never been, and never will be, apolitical. It is antithetical to advocate for my queer and trans community in Atlantic Canada without equally calling for the liberation of queer and trans Palestinians. I cannot claim to be dedicated to disability justice and remain silent while Israel kills disabled Palestinians and disables those who survive. This project is centred on my immediate community, but I want to make clear that my work is rooted in the knowledge that all systems of oppression are intertwined. As a queer person, I do not support Israel's weaponization of the queer struggle for liberation in their colonial violence against Palestinians. Our oppression is linked; our liberation is inseparable from decolonization and the liberation of all oppressed people.

This is the position from which I approached this research. Conducting research within my own community, on a topic so pertinent to myself and to my community, has been indescribably rewarding. It has also been difficult and complex. Much has been written about the complexities of conducting "insider" research (e.g., Berkovic et al., 2020; Tuffour, 2018), and the additional aspect of shared MI among both myself and my participants only added further complications. As the researcher, I had a responsibility to reduce risk of harm for participants,

and I drew significantly from my own experiences with MI and suicidality in designing and implementing safeguards (detailed in the Methodology section). Data collection involved navigating participants' triggers and boundaries alongside my own, while also balancing the shifting power dynamics involved in interviewing participants who were also my close friends. Further, I completed recruitment, data collection, transcription, analysis, and writing within the six months immediately following my dad's very unexpected death. It has been, quite frankly, a bizarre experience. To have put so much of myself into a research project about suicide and MAID, while dealing with my dad's death and being immersed in sometimes deeply sorrowful participant interviews, was to be bombarded by grief from all sides. I interviewed my 30th participant on the one-year anniversary of my most recent suicide attempt. As Black geographer Priscilla McCutcheon writes: "I am passionate about my research, but readily admit that being both the voice and the thing itself is emotionally taxing" (Kohl & McCutcheon, 2015, p. 754). It is difficult to study queer death and queer MI as a suicidal, mentally ill queer person. I have leaned heavily on those at my "kitchen table", and I cannot thank them enough for the hours spent sitting with me and my emotions.

I am exceedingly grateful to every participant who trusted me with their experiences and who held space for mine; sharing space with participants in this way was equally validating, healing, and painful. While I know that it is impossible to extricate myself from the presentation of this research, my goal with this project has always been to highlight community perspectives; I have endeavored to represent my participants' and their words authentically, such that their voices are heard and not distorted. I hope that in these results, people in my community can see themselves represented, and I hope that eventually, we will see ourselves represented in MAID policy as well.

Methodology

This study engaged 2S/LGBTQ+ adults with MI living in Atlantic through semi-structured qualitative interviews. Specifically, we utilized the methodology of interpretive description, informed by a feminist-of-colour disability framework and community collaboration. I will now describe each of these in greater detail.

Interpretive description is a relatively recently developed methodology, initially employed in nursing and other applied disciplines. It arises from a constructivist paradigm and is characterized by the recognition of subjective knowledge as valuable; an emphasis on the impact of time, context, and environment on an individual's experiences and perspectives; co-creation of knowledge between researcher and participant; and the intention for resulting knowledge to have practical, rather than exclusively theoretical, implications (Thorne, 2016). Interpretive description was developed by nurse researchers as an alternative to qualitative methodologies such as grounded theory, ethnography, and phenomenology. These researchers sought to conduct research that would tangibly impact their policies and practice; many nurses had been conducting such research using distinct and consistent methodological reasoning, but this research was considered "sloppy" because it did not fit any of the established methodological traditions (Morse, 1991). With the goal of "retain[ing] the coherence and integrity of a theoretically driven approach to knowledge development while supporting defensible design variations according to the specific features of context, situation, and intent" (Thorne, 2016, p. 30), nurse researcher Sally Thorne tailored the methodology of interpretive description for applied research that decenters purely theoretical outcomes.

Interpretive description has recently been proposed as a methodology that aligns with the principles of anti-oppressive research. The fluidity and flexibility of the methodology permits the

continuous shaping of research protocol in order to suit the needs of participants; it "values effectiveness over adherence to tradition" (Ocean et al., 2022, p. 7), allowing "researchers to honor participants without forcing them to conform to undue methodological rigidities holding an abstract appointed value" (p.6). This is of particular significance in studies such as this one, in which there is a range of (dis)abilities represented in both the participants and the researcher which may require accommodations. Further, in interpretive description, the researcher is an active "participant" in the creation of knowledge, and is encouraged to bring their own lived experience and identity into the research, particularly when the researcher in question is a professional in the field (as in the case of nurse researchers) or an "insider" in the community of study (as in the case of this study). Though there has been increasing criticism and decreasing acceptance of extractive "outsider" research, Aguilar et al. (2023) note that insider research (or "me-search") has also been vilified due to presumed "subjectivity, potential bias, concerns about validity, perceived narcissism, limited generalizability, and lack of rigor" (p. 7). The aggrandizing of "objectivity" inherently devalues marginalized researchers, particularly BIPOC, who seek to conduct research within their communities. As a methodology, interpretive description rejects the notion that "community membership [is] something of a researcher bias", and instead encourages researchers to "bring themselves fully into the research" (Ocean et al., 2022, p. 6).

Understanding that knowledge is created in the interaction between the researcher and participant, interpretive description "recognizes that there is often no strict boundary between researcher and researched, and therefore invites scholars to build and sustain relationships that reduce objectifying" research participants (Ocean, 2022). This is conducive to the incorporation of elements of community-based research into the research design. Community-based research

challenges the problematic framing of researcher as "expert" and the predominance of "top-down" research, in which research is conducted *on* communities rather than *with* communities (Minkler, 2005). Methods that are community-based/collaborative are increasingly utilized in research with 2S/LGBTQ+ populations (e.g., (Delmonaco et al., 2023; Rubini et al., 2023) and are grounded in decolonial, non-extractive approaches to research (Fals-Borda, 1987; Igwe et al., 2022). Though this project did not employ all of the fundamental tenets of community-based research, I endeavored to engage with community throughout my research design and process (further described in the subsequent section).

Interpretive description is additionally useful for in-depth description of complex phenomena that lack previous exploration and that are located in mutually constitutive systems of oppression (Kalengayi et al., 2012; McCall et al., 2009). Where the experiences and perspectives of the population and phenomena of interest in this study are embedded in a colonial, ableist, capitalist heteropatriarchy (e.g., Gaind et al., 2022), a methodology that honors complexity and social context is valuable. As interpretive description is compatible with a range of theoretical frameworks, to further emphasize these systemic factors, for this study we draw from a feminist-of-colour disability[3] framework, which "highlights the ideological and rhetorical

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[3] The label and identity of "disabled" is fraught with complexity. Many people, especially those already multiply marginalized, choose to distance themselves from this identity due to the stigma attached to it, due to historic exclusion from mainstream disability rights movements, or simply because disability is the norm, rather than the exception, in certain communities. Following the lead of disability justice activists and intersectional disability scholars (e.g., Schalk; Pieri) in this proposal I use an expansive definition of "disability" and "disabled" that recognizes "the collective affinities among disabled, impaired, sick, ill, and Mad people, who are connected not by essential or inherent qualities but by the related oppressions we experience for our nonnormative bodyminds" (Schalk, 2022, p. 9).

deployment of ableism within legacies of… oppressive practices and structures" and "analyze[s] the intersecting systems of ableism, heteropatriarchy, white supremacy, and capitalist violence, particularly as they assign value or lack thereof to certain bodyminds[4]" (Schalk & Kim, 2020, p. 37-38). Developed by Sami Schalk and Jina B. Kim (2020), a feminist-of-colour disability framework builds on the work of scholars such as Audre Lorde, Rosemarie Garland-Thompson, Nirmala Erevelles, Julie Minich, Jasbir Puar, Moya Bailey, and Izetta Mobley, and incorporates elements of feminist-of-colour critique, feminist disability studies, queer theory, and crip theory. It moves beyond identity politics and individualized constructs of "disability" in order to understand and critique the ways in which intersecting systems of oppression both create and define disability and impairment. It necessitates inquiry of how ableism has been weaponized as a tool to further oppress and disable marginalized communities, and recognition of how our understanding of disability is inherently influenced by race.

This framework was developed to disrupt the dominant (white) narratives in feminist disability studies and to evince the mutual integrality of race, gender, and disability studies. In doing so, Schalk and Kim complicate the concepts of "disability" and "disabled"; they write that a feminist-of-colour disability framework understands "disability as a relationship to power rather than a legible identity to which one can lay claim" (p.38). Utilizing this theoretical framework permitted investigation of the population's perspectives within the context of social structures of oppression and within the context of experiences within these social structures.

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[4]"Bodymind" is a feminist disability studies concept used to express the inseparability of body and mind under structural power and violence; see Price, 2015.

Ethical considerations and collaborative research design

I engaged five community advisors for this project, including individuals with MI as well as mental health professionals. All were 2S/LGBTQ+ Atlantic Canadians and all four Atlantic Canadian provinces were represented. I began consulting with my community advisors during research design, prior to applying for ethics approval. I met with each of them individually at least once, and with some of them multiple times, to collaborate on creating the interview guide and constructing safeguards for participants in order to explore the research question in a way that was safe, ethical, and effective. They provided valuable feedback and insight, particularly in reference to question wording and eligibility criteria, and were instrumental in the development of safeguards for participants.

Before commencing this research, ethics approval was obtained from the University of Victoria Human Research Ethics Board (H23-0253, Appendix A). Due to the subject matter of the study, several additional precautions were established to ensure that potential for harm to participants was minimized. First, participants were provided with a copy of the interview questions prior to beginning the interview and were able to identify any questions or topics that they did not wish to discuss during the interview. Second, participants also had the option to provide information for a support person who could be contacted in case of a crisis situation. Significantly, participants were given the opportunity to debrief with a qualified 2S/LGBTQ+ counsellor free of cost (funded by our study), either on the same day as the interview or within ten business days following the interview.

It is also important to note the common misconception that enquiring about suicidal ideation increases risk of suicide. A 2014 review by Dazzi et al. concluded that no studies found

a statistically significant link between enquiring about suicide and increased suicidal ideation in participants.

Participants, recruitment, and data collection

This study used a purposive and convenience sampling approach. Recruitment materials (see Appendix B for examples) were distributed widely and through various channels, including email blasts and social media posts from organizations such as Egale Canada, Community Based Research Centre, Our Landing Place, and the PEI Transgender Network; public radio interviews about the study; physical posters placed on university campuses; and word of mouth. Individuals interested in participating were directed to fill out a brief screening survey that confirmed their eligibility (Appendix C); this survey also gave participants the opportunity to disclose any identities or lived experiences important to them in order to allow us as researchers to purposively maximize diversity of the study sample.

Because this research aimed to explore opinions of those who could be affected by the legalization of MAID-MI, only those who met the logistical criteria (excluding professional diagnosis/assessment from medical professionals) for MAID-MI were eligible for this study. This means that the project did not engage children (18 years of age or younger), or those who are ineligible for federally/provincially-funded health services (Government of Canada, 2023). Eligibility criteria were as follows;

1) Over the age of 19 years, based on the age of majority in Nova Scotia, New Brunswick, and Newfoundland;
2) Identify as 2S/LGBTQ+;
3) Have a mood disorder (e.g., depression, bipolar, dysthymia/persistent depressive disorder), with or without a formal diagnosis;

4) Have some knowledge of MAID in Canada;
5) Have lived in Atlantic Canada (New Brunswick, Newfoundland, Nova Scotia, PEI) for at least 5 years;
6) Able to communicate and understand English;
7) Eligible for federally/provincially-funded health services.

We chose to focus specifically on mood disorders, as it is those with mood disorders who make up the majority of requests for MAID-MI in the Netherlands and Belgium (Kim et al., 2016; Dierickx et al., 2016; Pronk et al., 2021b). Following the example of existing literature (Hall et al., 2020; Miller & Smith, 2021) and considering the discrimination that 2S/LGBTQ+ individuals face in the healthcare system, individuals did not need to provide/have a diagnosis in order to participate in our study. For the purposes of this study, we defined mood disorder as "a disorder that causes disruption in one's mood". Recognizing that medical categorizations do not always reflect individuals' lived experiences, especially for those who may be racialized, 2S/LGBTQ+, or otherwise marginalized, we did not limit eligibility to those who had typical named mood disorders such as depression or bipolar disorder. Instead, we allowed prospective participants to assess for themselves whether they identified as having a "mood disorder" based on the definition provided. Knowledge of MAID in Canada was assessed through two "true or false" questions and one open text question in the initial screening survey (see Appendix C). We defined an "Atlantic Canadian" as someone who had lived in Atlantic Canada for at least five years, past or present, based on conversations with community advisors and other community members.

Recruitment began on February 5th, 2024, and ended on March 18th, 2024. Approximately 85 individuals filled out the screening survey (exact numbers are not available, as ineligible

participants' responses were deleted immediately), and 66 individuals were deemed eligible to participate. The majority of these individuals disclosed aspects of themselves related to disability (neurodivergence, chronic illness, mobility impairments, etc.), rurality, socioeconomic status, race, gender, sexuality, age, occupation or other aspects of lived experience in the screening survey; I used this information to purposively select participants, with the aim of maximizing diversity along various axes. I emailed selected participants an invitation to participate in the study, which included: additional information about the study; a link to a questionnaire that included the consent form, demographics, and accessibility needs (Appendix D); a copy of the interview guide (Appendix E); a document of mental health resources; a fact sheet about MAID (Appendix F); and a document with grounding strategies. In total, 51 individuals were invited to participate in the study, 41 individuals filled out the Demographics, Accessibility, and Consent questionnaire, and 38 individuals participated in an interview.

The Demographics, Accessibility, and Consent questionnaire acted as the initial informed consent provision for the study, and also collected information on participants' demographic information (age, race/ethnicity, gender, socioeconomic status, etc.) as well as their current province of residence and what Atlantic province(s) they previously lived in. This questionnaire also collected additional information relevant to conducting the study in an ethical, community-driven, and participant-centred way. For example, as a member of the community of interest, I recognize that language, and particularly language pertaining to identity, is often important; it was therefore important to allow participants to identify language that felt most comfortable to them. In the Demographics, Accessibility, and Consent questionnaire, participants were asked to identify how they would like to be referred to during the interview, in questions that asked them to reflect on their identities (e.g., What was your experience navigating the world as a [insert

identity] person in Atlantic Canada?), as well as the terminology they preferred to use surrounding MI (e.g., MI, mood disorder, disability). Participants also selected whether they would prefer to be referred to with a pseudonym or participant number and what descriptors (e.g., race, disability status) they were comfortable being attached to in any research outputs.

Recognizing the variety of (dis)abilities within the sample (Price & Kerschbaum, 2016) and that not everyone is comfortable/able to participate in a video call or communicate verbally, participants had the option to engage in the interview through a video call or through a live chat, both via Zoom. Additionally, participants were asked if they had any specific accessibility needs or accommodations that would support their participation in the study. All participants chose to complete the interview via Zoom video/audio call. To minimize risk of emotional discomfort during the interview, participants were asked to review the interview guide beforehand and identify any questions/topics they wanted to avoid in the Demographics, Accessibility, and Consent questionnaire, and were given an additional opportunity to do so prior to starting the interview. Participants could provide information for a support person who could be contacted in case emotional distress occurred during the interview.

We also collaborated with Our Landing Place, a 2S/LGBTQ+ counselling collective, to provide all participants with the opportunity to debrief with a qualified 2S/LGBTQ+ counsellor free of cost. Participants could choose to debrief either on the same day as the interview or within ten business days following the interview, as we were aware that some individuals may want/need time to reflect individually before debriefing, and that difficult emotions may be delayed in onset and may not arise immediately during the interview. Participants indicated in the Demographics, Accessibility, and Consent questionnaire which option they preferred. Use of

the debrief was fully confidential except for those who chose to debrief on the same day, as in those cases I needed to be involved in scheduling.

Once participants had filled out the Demographics, Accessibility, and Consent questionnaire, I contacted them to schedule the interview. I conducted all of the interviews. Before beginning each interview, I acknowledged the traditional extractive nature of interviewing and introduced myself along with a disclosure of my positionality in respect to the study. There has been considerable discussion regarding the practice of researcher self-disclosure in qualitative interviews (e.g., Ross, 2017); for myself as a researcher, self-disclosure was important for several reasons. As someone who exists at the intersection of several marginalizations, I am very aware of the ways in which research has been weaponized against marginalized communities and how this has often been facilitated by outsider researchers. While all recruitment materials as well as the consent form identified that interviews would be conducted by a queer, trans individual from PEI, I wanted to re-state my position as a part of my community and be as transparent as possible with respect to my reasons for conducting this research. I also wanted participants to be aware of my mannerisms (i.e., lack of eye contact, fidgeting) and potentially atypical way of engaging in conversation to avoid any misunderstandings during the interview. By self-disclosing before the interview, I avoided the risk of distracting from the participants' narrative if choosing to self-disclose during the interview, and this also allowed participants to engage with my self-disclosure in whatever way was most comfortable for them. I informed participants that the interview was meant to centre their experiences and perspectives as much as they were comfortable with, but also invited them to ask any questions of me before or during the interview to facilitate dialogue.

The interview guide (Appendix E) covered a range of topics, including experiences seeking mental healthcare in Atlantic Canada, perspectives on the legalization of MAID-MI, and conceptualizations of suicide and MAID. In several questions, participants were asked to reflect on their identities and on how their identities impacted their perspectives. Before questions that included reference to suicide, participants were given a brief verbal warning and a reminder that they were free to skip the question. Interviews were recorded through Zoom and all participants were given a $50 cash honorarium.

In total, I conducted 38 interviews between February and April 2024; interviews took place via Zoom video call and ranged in length from 32 minutes to 2.5 hours. The majority of participants (n=33) resided in Atlantic Canada at the time of the interview, and Nova Scotia was most highly represented both as participants' current and previous province of residence. Of the 38 participants, 24 were white and the remaining 14 participants represented diverse races/ethnicities: Indigenous, First Nations, Métis, or Inuit; Black; East or Southeast Asian; Latino/Latina/Latine/Latinx; and South Asian. A minority (n=9) identified as cisgender. Though over half of the sample were aged 20-29, participants ranged in age from 19 to 64. Depression was the most commonly reported mood disorder (n=31), followed by PTSD/C-PTSD (n=8), anxiety (n=8), dysthymia/persistent depressive disorder (n=6), and bipolar disorder (n=5). Other reported mood disorders (n=6) included panic disorder, obsessive compulsive disorder, borderline personality disorder, seasonal depression, and dissociative identity disorder.

Table 1:

Demographic characteristics and mood disorder(s) of study participants (N=38), 2024

	n	%

Atlantic province(s) lived in (past/current)		
New Brunswick ever	11	28.95%
Newfoundland ever	12	31.58%
Nova Scotia ever	18	47.37%
Prince Edward Island ever	7	18.42%
Multiple Atlantic provinces ever	8	21.05%
Current province lived in		
British Columbia	3	7.89%
New Brunswick	6	15.79%
Newfoundland	10	26.32%
Nova Scotia	12	31.58%
Ontario	2	5.26%
Prince Edward Island	5	13.16%
Race		
Racialized	14	36.84%
White	24	63.16%
Gender Identity[1]		
Agender	1	2.63%
Genderfluid	7	18.42%
Genderqueer	16	42.11%
Cisgender man	1	2.63%
Cisgender woman	8	21.05%
Trans woman	1	2.63%

Non-binary	11	28.95%
Transmasculine	7	18.42%
Two-Spirit	4	10.53%
Other	3	7.89%
Sexual Orientation[1]		
Asexual	5	13.16%
Bisexual	8	21.05%
Lesbian	10	26.32%
Pansexual	6	15.79%
Queer	30	78.95%
Questioning	1	2.63%
Straight	1	2.63%
Two-Spirit	4	10.53%
Other	1	2.63%
Age group (in years)		
<20	1	2.63%
20-29	22	57.89%
30-39	9	23.68%
40-49	2	5.26%
50-59	2	5.26%
60+	2	5.26%
Financial situation, current		
Cannot make ends meet	7	18.42%

Have to cut back	8	21.05%
Enough, but no extra	10	26.32%
Comfortable, with extra	12	31.58%
Mood disorder, mutually exclusive[1]		
Depression	31	81.58%
Anxiety	8	21.05%
Bipolar disorder	5	13.16%
Dysthymia/persistent depressive disorder	6	15.79%
PTSD/C-PTSD[2]	8	21.05%
Other	6	15.79

[1]Percentages exceed 100% as participants could select multiple options.

[2]Post-traumatic stress disorder/complex post-traumatic stress disorder

Analysis

Concurrent data collection and analysis is fundamental to an interpretive description methodology; transcription and preliminary analyses therefore occurred as data were still being collected. This allowed me to gain greater insight into the data I was collecting, and to use those insights to inform future interviews. Each interview was transcribed verbatim and all identifying information (names, specific locations, businesses, hospitals, schools, organizations, etc.) that would link the interview to the participant was redacted. Interpretive description is also conducive to the continued engagement of participants through opportunities for participants to review transcripts and preliminary coding/analyses (Thorne et al., 1997; Thorne, 2016). Continued engagement enhances the credibility of qualitative research, as it allows participants to ensure that they are being represented in such a way that is true to their perspectives and

experiences. Participants could opt in to transcript and analysis review; those that did so were sent their transcript as well as an overview of preliminary analyses and were given the opportunity to provide feedback.

The goal of analysis in interpretive description is not to create a foundation for a new theory, but instead to "engage in a dialectic between theory and the data" (Thorne et al., 2004) in order to identify a set of themes that represent the data accurately and coherently. Reflexive thematic analysis (Braun & Clarke, 2021), as it offers theoretical flexibility, was therefore a suitable method for analysis, and has been used in previous interpretive descriptive studies (e.g., Kalengayi et al., 2012; McCall et al., 2019). Reflexive thematic analysis, as its name suggests, also emphasizes researcher reflexivity and subjectivity, which aligns with the core characteristics of interpretive description (Thorne, 2016). Reflexivity was a core part of this project, given my positionality and relationship to the community at hand, and it was essential to use a method of analysis that recognizes the way that researcher identity and theoretical background inherently influence analysis, just as they inherently influence every other aspect of the study. The six distinct yet recursive phases of reflexive thematic analysis are 1) familiarisation with the data, 2) coding, 3) initial theme generation, 4) theme development and review, 5) theme definition and refinement, and 6) writing.

Familiarisation with the data occurred while I conducted interviews, transcribed the interviews, and later re-read each interview. As I conducted and transcribed interviews, I began to identity broad areas of interest to explore in more depth, including openness about MI and suicide within queer communities, conceptualizations of MAID-MI as harm reduction or as harm, impact of identity on views about MAID-MI, and MAID-MI in the context of Atlantic Canada. For this thesis, I decided to focus on MAID-MI in the context of Atlantic Canada's

healthcare system. I worked through the entire dataset several times, beginning with more inductive and semantic coding, and creating more latent and theory-driven codes as my understanding of the data deepened. Phases three to six occurred recursively as I created, revised, and discarded themes, facilitated by feedback from participants, discussions with peers and supervisors, and time spent away from the data. My initial themes attempted to differentiate structural/operational issues with the healthcare system from issues arising from discrimination and bias, and broke this down further to separate systemic-level problems from individual provider-level problems. After further reflection and engagement with the data, I recognized that these themes functioned more as topic summaries; further, I identified that the ideas of autonomy and choice, and specifically the lack thereof, were pervasive across the dataset. I therefore constructed an overarching theme around the topic of choice and autonomy: "*Who has the right to decide?*", with three themes supporting the position that the healthcare system in Atlantic Canada is not prepared to implement MAID-MI in a way that respects autonomy and choice. This was conducive to the goal of interpretive description to situate data in conversation with existing theory and policy, as this framing of my analysis engages with existing discussion around MAID as a source of autonomy and with my theoretical framework, which emphasizes power and intersectionality.

The following chapter is written and formatted for submission as a journal article to Social Science and Medicine.

Chapter 2: "We're just really, really far from that": Queer Atlantic Canadian perspectives on healthcare system preparedness for medical assistance in dying for mental illness

Highlights

- 2S/LGBTQ+ people discuss medical assistance in dying for mental illness.
- Patient autonomy is significant in medical assistance in dying.
- Barriers to healthcare access can restrict autonomy.
- Excessive power given to healthcare providers is viewed as problematic.
- Coercion and force are identified as potential risks for vulnerable populations.

Abstract

In March 2027, medical assistance in dying (MAID) in Canada will be available to those with mental illness (MI) as the sole underlying condition (MAID-MI). The literature surrounding MAID-MI rarely consults individuals with MI; consequently, there is urgent need to understand this population's perspectives.

This study used an interpretive description methodology, informed by a feminist-of-colour disability framework, and community collaboration. We engaged 2S/LGBTQ+ Atlantic Canadians with mood disorders through 38 qualitative interviews, and using reflexive thematic analysis, we explored participants' perspectives on MAID-MI, autonomy, and choice in the context of Atlantic Canada's healthcare system.

Participants discussed their experiences accessing healthcare and overall expressed that the healthcare system is unprepared to implement MAID-MI in a way that prioritizes patient autonomy and choice. First, participants described systemic failures in the healthcare system and a lack of resources and treatment options for MI, particularly for 2S/LGBTQ+ or otherwise marginalized individuals; this lack of options disempowers individuals and complicates the

concept of autonomy in choosing MAID-MI. Second, participants also problematized the role of healthcare providers in making decisions about who can (and cannot) die by MAID-MI, identifying healthcare provider bias, discrimination, and pathologization of 2S/LGBTQ+ identities as potential issues. Third, participants expressed concern about MAID-MI being used coercively or without consent in an effort to reduce strain on the healthcare system.

These results identify possible complications for MAID-MI implementation, and highlight areas where additional safeguards could be enacted to ensure equity and prevent abuse of power, particularly for 2S/LGBTQ+ or other marginalized communities.

"We're just really, really far from that": Queer Atlantic Canadian perspectives on healthcare system preparedness for medical assistance in dying for mental illness

Introduction

Medical assistance in dying (MAID) is a highly debated topic in fields such as medical ethics, palliative care, and psychology, with both staunch supporters and opponents. In March of 2027, eligibility for MAID in Canada will be expanded to include those with mental illness (MI) as the sole underlying condition. This expansion is controversial, and recent years have seen a drastic increase in research and publications seeking to understand and express perspectives on medical assistance in dying for MI (herein MAID-MI). Research has disproportionately highlighted the opinions of physicians, nurses, lawyers, ethicists, and others considered experts in the field, and has only recently begun to include people with MI themselves (e.g., Bastidas-Bilbao et al., 2023). There remains a lack of research investigating the perspectives of marginalized people (2S/LGBTQ+, racialized, unhoused, and disabled people, etc.), who experience MI at

disproportionately high rates due to the compounding impact of racism, homophobia/transphobia, ableism, and other forms of discrimination.

MAID in Canada. MAID was first legalized in Canada in 2016 following the Supreme Court case *Carter v. Canada* (*Carter v. Canada*, 2015). At the time, in order to be eligible for MAID, an individual was required to have a "grievous and irremediable medical condition", and their natural death needed to be "reasonably foreseeable", among other requirements. Under these parameters, 21,589 individuals died by MAID between 2016 and 2020, growing rapidly from 1018 deaths in 2016 to 7,595 deaths in 2020 (Second Annual Report, 2021). In 2021, Bill C-7 was enacted in Canada and 1) repealed the requirement that natural death must be reasonably foreseeable in order to be eligible for MAID, 2) established that MI *does not* qualify as a grievous or irremediable medical condition for the purposes of MAID eligibility, and 3) added a provision that the disqualification of MI would be automatically repealed two years following the passing of Bill C-7 (Nicol & Tiedemann, 2021). Under this new legislation, 10,092 individuals died by MAID in 2021 and 13,241 individuals died by MAID in 2022, bringing the total number of medically assisted deaths in Canada to 44,958.

The rapid increase in number of MAID deaths has led to questions regarding who, exactly, is dying by MAID in Canada. It is well known that disabled individuals are disproportionately likely to live in poverty, and cost prevents many disabled people from being able to access the medications, aids, devices, or supports they require (United Nations General Assembly, 2019b). Many concerns have been raised (e.g., Special Joint Committee, 2022b) that inability to access such supports will push disabled individuals toward choosing MAID. While the original requirement of a "reasonably foreseeable death" provided somewhat of a safeguard against these concerns, the introduction of Track 2 MAID has resulted in multiple publicized cases of

individuals who qualified for and chose to die by MAID, but would not have done so if they had stable housing and finances (e.g., Alberga, 2022). A recent report from Canada's Special Joint Committee on Medical Assistance in Dying asserted that "those who are accessing MAID in Canada are not marginalized individuals" (Special Joint Committee, 2023, p.14). However, no data were collected as to the race, gender identity, sexuality, disability status, or socioeconomic position of those who died by MAID between 2016 and 2022 (Fourth Annual Report, 2023). The absence of this information has done little to assuage fears that individuals are choosing MAID due to factors of structural vulnerability, and that this trend will continue when MAID-MI is legalized.

The two-year waiting period for MAID-MI was extended for an extra year in February of 2023, and was subsequently extended for an extra three years in February of 2024, reportedly due to the unpreparedness of the healthcare system to safely and equitably implement MAID-MI (Government of Canada, 2024). Introducing MAID *for MI* as a publicly-funded healthcare service has unique implications, given that treatment for MI is scarcely covered under Canada's medicare system. Canada boasts publicly-funded, "universal coverage for medically necessary health care services", (*Canada's Health Care System,* 2019)but mental health care in Canada is only government-funded if it is provided in a hospital or by a physician. For other facets of mental health care – including psychological services, counselling, and medications – people in Canada rely either on private insurance coverage or must pay out of pocket. This inherently introduces inequity as to who can financially afford to access mental health care; further, quality and availability of services varies between Canadian provinces (e.g., Kay, 2023).

Atlantic Canadian Context. The Atlantic Canadian region is located on the east coast of Canada and includes four provinces: New Brunswick (NB), Nova Scotia (NS), Prince Edward

Island (PEI), and Newfoundland and Labrador (NL). Of the ten Canadian provinces, the four Atlantic provinces are the smallest both geographically and by population, and the region is known for its rapidly aging population (Smellie, 2022) and its low rates of racial diversity (The Canadian Census, 2022) in comparison with other Canadian provinces. All four Atlantic provinces have higher proportions of individuals living in rural areas than the Canadian average (Population Growth, 2022).

Consistent with the rest of Canada, rates of MAID provision have increased yearly in the Atlantic provinces, with NL in particular experiencing a 38.5% increase in MAID deaths between 2021 and 2022 (Fourth Annual Report, 2023). In respect to the upcoming legalization of MAID-MI, issues of social and structural vulnerability may be particularly applicable in the Atlantic region. Along with astronomical rent increases causing high rates of homelessness and poverty (King & Cooke, 2024), the region is also experiencing a healthcare crisis. Wait times to access care are long and only increasing, particularly for gender-affirming care and mental healthcare; individuals are waiting years for assessment for gender-affirming care (Armstrong, 2022), and trauma survivors in crisis suffer for months without mental healthcare (Ryan, 2022). Financial struggles, rurality, and inability to access care create a perfect storm for poor mental health and suggest concerning implications for MAID-MI implementation in the region.

In this study, we aim to explore how 2S/LGBTQ+ Atlantic Canadians with MI conceptualize the upcoming implementation of MAID-MI into the Atlantic Canadian healthcare system.

Methodology

Study design. We designed the study within an interpretive descriptive methodology (Thorne, 2016) and situated it in a feminist-of-colour disability framework (Schalk & Kim, 2020) to align

with the principles of anti-oppressive research (Ocean et al., 2022). The fluidity and flexibility of the methodology permits the continuous shaping of research protocol in order to suit the needs of participants; it "values effectiveness over adherence to tradition" (13, p. 7) allowing "researchers to honour participants without forcing them to conform to undue methodological rigidities" (13, p.6). This is of particular significance in studies such as this one, in which a range of (dis)abilities, some requiring accommodations, was represented in both the participants and the researchers. Further, interpretive description is useful for in-depth description of complex phenomena that lack previous exploration and that are located in mutually constitutive systems of oppression (Kalengayi et al., 2012; McCall et al., 2009). Where the experiences and perspectives of the participants are embedded in a colonial, ableist, capitalist heteropatriarchy, a methodology that honours complexity and social context is valuable.

Theoretically, the study was informed by a feminist-of-colour disability framework, which "highlights the ideological and rhetorical deployment of ableism within legacies of… oppressive practices and structures" (Schalk & Kim, 2020, p. 38). Developed by Sami Schalk and Jina B. Kim, a feminist-of-colour disability framework incorporates elements of feminist-of-colour critique, feminist disability studies, queer theory, and crip theory, and moves beyond identity politics and individualized constructs of "disability" in order to understand and critique the ways in which intersecting systems of oppression both create and define disability and impairment. It necessitates inquiry of how ableism has been weaponized as a tool to further oppress and disable marginalized communities, and recognition of how our understanding of disability is inherently influenced by racism. This framework was developed to disrupt the dominant (white) narratives in feminist disability studies and to evince the mutual integrality of race, gender, and disability studies.

Sampling and recruitment. Recruitment materials were distributed widely and through various channels, including email blasts, social media, radio, physical posters, and word of mouth. Individuals interested in participating were directed to fill out a brief screening survey to assess eligibility; this survey also gave participants the opportunity to disclose any identities or lived experiences important to them. In order to be eligible, individuals needed to meet the following criteria: 1) over the age of 19; 2) identify as 2S/LGBTQ+; 3) have a mood disorder; 4) have some knowledge of MAID in Canada; 5) have lived in Atlantic Canada for at least 5 years; 6) able to communicate and understand English; and 7) be eligible for federally/provincially-funded health services. For the purposes of the study, we defined mood disorder as "a disorder that causes disruption in mood". Acknowledging barriers to healthcare and that medical categorizations are not always reflective of individuals' lived experiences, especially for those who are racialized, 2S/LGBTQ+, or otherwise marginalized, we did not require participants to have a formal diagnosis. Purposive sampling was used to maximize diversity in the sample. Individuals selected to participate provided informed consent through an online questionnaire before scheduling an interview time, and verbally re-affirmed consent prior to beginning the interview.

Ethical considerations. Ethics approval for this protocol was obtained from the University of Victoria Human Research Ethics Board (H23-0253). Due to the subject matter of the study, several additional precautions were established through consultation with five community advisors to ensure that potential for harm to participations was minimized. First, participants were provided with the interview questions prior to the interview, and could identify any questions or topics that they wished to avoid during the interview. Second, participants could provide information for a support person who could be contacted in case of crisis. Third, and

significantly, participants had the opportunity to debrief with a qualified 2S/LGBTQ+ counsellor free of cost, either same day or within ten business days following the interview, as we were aware that some individuals may want/need time to reflect individually before debriefing, and that difficult emotions may be delayed in onset and may not arise immediately during the interview.

Data collection. The first author (JT) conducted individual interviews between February-April 2024. Interviews took place via Zoom video call and ranged in length from 32 minutes to 2.5 hours. All interviews began with a disclosure of JT's positionality in respect to the project: JT is a queer/trans, disabled, Asian Canadian person from PEI with lived experience of MI and suicidality. The interview guide was created in collaboration with community advisors, and covered a variety of topics, including experiences seeking mental healthcare in Atlantic Canada, perspectives on the legalization of MAID-MI, and conceptualizations of suicide and MAID. Prior to the interview, all participants were sent a fact sheet about MAID legislation in Canada and were given the opportunity to ask any clarifying questions.

Data analysis. Transcription and preliminary analyses occurred concurrently with data collection. In interpretive description, analysis aims to "engage in a dialectic between theory and the data" (Thorne et al., 2004, p. 6); reflexive thematic analysis (Braun & Clarke, 2021) was therefore a suitable method for analysis, as it offers theoretical flexibility. It also emphasizes researcher reflexivity and subjectivity, which aligns with the core characteristics of interpretive description (Thorne, 2016). Reflexivity was a core part of this project, given researchers' positionality and relationship to the community at hand, and it was essential to use a method of analysis that recognizes the way that researcher identity and theoretical background inherently influence every aspect of the study.

Each interview was transcribed verbatim and all identifying information was redacted. The six phases of reflexive thematic analysis were conducted by JT and facilitated through discussion and feedback from participants, community members, and co-authors.

Results

Sample demographics. Overall, 66 individuals were deemed to be eligible and 38 individuals were interviewed, described in Table 1. The majority (n=33) resided in Atlantic Canada at the time of the interview, and Nova Scotia was most highly represented both as participants' current and previous province of residence. Of the 38 participants, 24 were white and the remaining 14 participants represented diverse races/ethnicities: Indigenous, First Nations, Métis, or Inuit; Black; East or Southeast Asian; Latino/Latina/Latine/Latinx; and South Asian. A minority (n=9) identified as cisgender. Depression was the most commonly reported mood disorder (n=31).

Table 2:

Demographic characteristics and mood disorder of study participants (N=38), 2024

	n	%
Atlantic province(s) lived in (past/current)		
New Brunswick ever	11	28.95%
Newfoundland ever	12	31.58%
Nova Scotia ever	18	47.37%
Prince Edward Island ever	7	18.42%
Multiple Atlantic provinces ever	8	21.05%
Current province lived in		
British Columbia	3	7.89%

New Brunswick	6	15.79%
Newfoundland	10	26.32%
Nova Scotia	12	31.58%
Ontario	2	5.26%
Prince Edward Island	5	13.16%
Race		
Racialized	14	36.84%
White	24	63.16%
Gender Identity[1]		
Agender	1	2.63%
Genderfluid	7	18.42%
Genderqueer	16	42.11%
Cisgender man	1	2.63%
Cisgender woman	8	21.05%
Trans woman	1	2.63%
Non-binary	11	28.95%
Transmasculine	7	18.42%
Two-Spirit	4	10.53%
Other	3	7.89%
Sexual Orientation[1]		
Asexual	5	13.16%
Bisexual	8	21.05%
Lesbian	10	26.32%

Pansexual	6	15.79%
Queer	30	78.95%
Questioning	1	2.63%
Straight	1	2.63%
Two-Spirit	4	10.53%
Other	1	2.63%
Age group (in years)		
<20	1	2.63%
20-29	22	57.89%
30-39	9	23.68%
40-49	2	5.26%
50-59	2	5.26%
60+	2	5.26%
Financial situation, current		
Cannot make ends meet	7	18.42%
Have to cut back	8	21.05%
Enough, but no extra	10	26.32%
Comfortable, with extra	12	31.58%
Mood disorder, mutually exclusive[1]		
Depression	31	81.58%
Anxiety	8	21.05%
Bipolar disorder	5	13.16%
Dysthymia/persistent depressive disorder	6	15.79%

PTSD/C-PTSD[2]	8	21.05%
Other	6	15.79

[1]Percentages exceed 100% as participants could select multiple options.

[2]Post-traumatic stress disorder/complex post-traumatic stress disorder

We identified that the ideas of autonomy and choice, and specifically the lack thereof, were pervasive across the dataset, and therefore constructed an overarching theme around the topic of choice and autonomy: "*Who has the right to decide?*", with three sub-themes, each represented by a participant quote, supporting the position that the healthcare system in Atlantic Canada is not prepared to implement MAID-MI in a way that respects autonomy and choice. In the first, *"Backed into a corner",* we explore the ways that Atlantic Canada's healthcare system disempowers individuals and limits their autonomy to freely choose MAID-MI. We discuss the role of healthcare providers (HCPs) in the second theme, *"Power over life and death*". In perhaps the most blatant form of removing individuals' autonomy, in the final theme *"An easier route to having less patients"*, we explore participants' worries about coercive use of MAID-MI.

Direct quotes are attributed either to a pseudonym of the participant's choosing or to a participant number (if participant preferred), along with descriptors selected by the participants.

"Backed into a corner": Conceptualizing "choice" in a failing healthcare system

Participants drew from their own, often less-than-ideal, experiences accessing healthcare to envision how MAID-MI will be implemented into the existing healthcare system in Atlantic Canada. They described a system that is "a nightmare" (P18, P22, Carmen), "overburdened" (P9, P32), "abysmal" (Jamie, P32) and "actively collapsing" (P29). One participant (P17 – queer, chronically ill, neurodivergent) explained:

> "…my health issues were getting worse and worse because of waiting lists, and because I did not have access to care. […]. It's kind of a lack of resources thing, and a lot of people end up getting like much more disabled, even like chronically and forever, because of the effects of illness that goes untreated or undiagnosed…"

A sense of hopelessness, futility, and frustration was evident in participants' experiences of healthcare access. Some participants had spent years on a waitlist to get a family doctor; others tolerated incompetent or discriminatory HCPs because there were no alternatives. While specialized services and gender affirming care were highlighted as particularly out of reach, no aspect of healthcare was widely characterized as easily accessible, including family doctors, walk-in clinics, and emergency services:

> "…this is the only [emergency room] in the province, and it's just like, it closes between midnight and eight, and you just kill yourself then, I guess." (P25 – lesbian)

A system that cannot provide basic healthcare services is a system that intrinsically complicates the notion of freely choosing MAID-MI. Part of the eligibility criteria for MAID-MI requires that a person's medical condition must be incurable and irreversible, which means that "there are no reasonable treatments [or interventions] remaining where reasonable is determined by the clinician and person together exploring the recognized, available, and potentially effective treatments…" (Model Practice, 2023). The *Criminal Code* mandates that an assessor must "ensure that the person has been informed of the means available to relieve their suffering…". Several participants problematized this mandated safeguard and highlighted that though these safeguards are meant to ensure equitable and consistent MAID provision, the concepts of "reasonable" and "available" are highly context-dependent. They questioned how this would be

applied in reality, particularly within a system where waitlists for treatment are frequently years long. P16 (neurodivergent, Two-Spirit Indigenous) described their concerns:

> "…my fear is that the people in my communities will not be forced, but will find it easier to access MAID than it is to access treatment, […], do you consider someone has exhausted all their treatments when they've tried a few things and are now on a waitlist for two years? Have they exhausted all their options or not? Because realistically that two-year wait is not a realistic option."

Many participants felt strongly that the MAID legislation had been created based on a presumed national standard of care and lacked consideration of regions like Atlantic Canada, "where the most mistakes could be made" (CJ). The uniqueness and severity of the issues in Atlantic Canada were particularly emphasized by participants who had experiences in other provincial healthcare systems.

> "I think if I was still in a province that had resources, […] I would probably be more favorable. I would probably be like, well, they can just go get treatment, and then after treatment they'll do this. But living in Atlantic Canada and all of these, it makes me skeptical." (P8 – queer, autistic, disabled).

> "I just really feel like there's this disconnect where the people who are making this legislation cannot conceive of the barriers to treatment. Go live in rural Nova Scotia for a year and then come back and write the MAID legislation." (P25 – lesbian).

Regularly evoked was the notion of being "backed into a corner" (P12 – genderqueer, disabled), where individuals would be choosing to die by MAID-MI because of a lack of other options.

> "Well, if MAID is wrote into policy, then for a lot of people, that would mean that the only resource is death." (P26 – queer, non-binary, neurodivergent).

> "…how can you fault people for being like, okay, then I'll do [MAID-MI], this is the only thing that will be publicly funded for me. And it's getting rid of me." (P18 – trans man)

> "I think there are people who wouldn't be as fortunate as I am, who would definitely see it as the only option because they can't get the support they need" (P30 – queer, disabled)

If death is, as participants referred to it, the "only real option" (P16), is "choosing" death really a choice freely made? Some participants took issue with the framing of MAID-MI as a victory for bodily autonomy:

> "…How about reproductive choice? How about autonomy to choose, like, trans affirming healthcare? And like, how about the autonomy to actually get healthcare of any kind? How about the autonomy to not be like forcibly committed to a hospital or a psych ward or whatever […]. And what kind is the autonomy to choose when you die, when you're being forced to it and not given the autonomy for anything else?" (Carmen – queer, racialized, disabled)

Carmen's sentiments echo existing arguments about the narrow conceptualizations of "autonomy" in debates around MAID (e.g., Beaudry, 2018), and reinforce the idea that having autonomy does not constitute simply the ability to make the decision to die with dignity, but rather that a truly autonomous person would have the option to live with dignity as well.

Participants discussed disparities of reasonable and available options on a broad level, drawing attention to the overall lack of resources in Atlantic Canada, but also emphasized inequitable distribution of the resources that do exist. Many participants expressed concern about the exceptional lack of resources for people living rurally, which comprises a significant portion of the Atlantic Canadian population (Population Growth, 2022). Those who were able to access resources were often able to do so out of luck or privilege:

> "Yeah. I feel like especially in Atlantic Canada, where we are living in a healthcare drought, both just like regular healthcare, but mental healthcare – like the only reason I'm alive is because my parents were able to financially support me, to finance a private psychologist." (P12)

Financial privilege was clearly a factor in individuals' ability to access treatment; many participants voiced that publicly-funded mental health programs did not have the capacity to meet demands, leaving people feeling "defeated" (Katherine), "disillusioned" (P14) and "in the dark with nothing" (Beckett). Participants were also cognizant of the intersectional aspect of access to care, including systemic and historic factors that make racialized and 2S/LGBTQ+ individuals more likely to be at financial disadvantage (e.g., Layland et al., 2022). Even outside of these factors, marginalization still directly impacted people's ability to access effective care given the lack of culturally competent providers, particularly for racialized participants:

> "When I was seeking help for suicidal thoughts and just general, incredible, deep depression and social anxiety and dissociation, disassociated identities, it was really hard for me to find anything that even knew what that was and what it would look like in a Black body, […]. It was really hard to find here, [to] listen to somebody who was very

> white and very middle class and come from a particular background trying to tell me how to, like, get better without even acknowledging any of my identities whatsoever, or even – it felt like I was teaching her things." (P32 – queer, Black, neurodivergent)

The necessity of culturally competent care was also evident in the experiences of trans participants, and in their conceptualization of MAID-MI:

> "…For trans and gender nonconforming people who want gender affirming care and can't get it [...], not having that available very much, definitely not surgery, but even like hormones and stuff not readily available here in Atlantic Canada, […], I think that makes it more likely for people with MI who are also not getting access to that care, more likely to use [MAID-MI]." (P11 – queer, bi-racial POC, physically disabled)

> "[MAID-MI] might be easier and take less time than transitioning, especially in Atlantic Canada, trying to get any kind of gender friendly care, they have to travel to different province outside of Atlantic Canada. […]. The accessibility of MAID versus everything else is starting to…. Like it's not an equal balance." (Howdy – trans, queer)

P11 and Howdy reference the inaccessibility of gender-affirming care in Atlantic Canada (e.g., Armstrong, 2022), with Howdy specifically drawing attention to the fact that some gender-affirming surgeries cannot be performed in some Atlantic Canadian provinces. Individuals on PEI, for example, are required to travel to Montreal for most gender-affirming surgeries (*Gender Affirming Health Services*, 2023). Some participants predicted that, like all healthcare in Atlantic Canada, MAID-MI would be difficult to access, making its legalization essentially inconsequential. Others suggested that people might travel for MAID-MI:

> "…a lot of our healthcare services we already travel for, and you know who's not to say that people will see this and say I can dump the money into a one-way ticket versus the amount of money it takes to go away for treatment." (Beckett – transmasculine)

Beckett identifies a fundamental inequality in the accessibility of MAID-MI compared with other treatment options, regardless of how difficult it is to access MAID-MI in Atlantic Canada. As an example, an individual from PEI getting top surgery must pay for travel to and from Montreal, accommodations, and food for both themselves and a support person (*GCS Approval Request Form*, 2023). This further requires the ability for the individual and their support person to take time off work. An individual travelling to receive MAID-MI, on the other hand, would face significantly fewer financial demands, along with the fact that they would ostensibly have no need to save finances for the future.

The question remains: if two options exist, but only one of them is financially accessible to a person, do they really have two options?

> "I think that MAID implies that people have a choice. And like, yeah, you have a choice if you're rich, […], you can go into inpatient, you can go into different, I don't know, little rehab treatment homes. We don't have very many of those in Nova Scotia. And when you're not rich, you depend on the public healthcare system. And if the options the public healthcare system are offering you is be traumatized by a psych ward or go get MAID, you don't have a lot of fantastic options." (P29)

As discussed by participants, autonomy to choose MAID-MI can be restricted by a lack of alternatives. However, even when an individual decides to pursue MAID-MI, the choice still may not be fully in their hands. This leads us to our next theme.

"Power over life and death": Empowering HCPs and disempowering patients

In legalizing MAID initially, the Supreme Court found that a ban on MAID violated the right to "make decisions concerning […] bodily integrity" (*Carter v Canada,* 2015*)*. Though the law may no longer constrain someone's bodily integrity in this way, participants' views suggest that when interpretations of safeguards are prone to subjectivity, decision-making power has, in effect, been passed not to the individual, but to the healthcare provider. Participants conceptualized the role of a HCP *ideally* as one of a helper, wherein the HCP would only support the individual's choice and ensure they were aware of their options. However, in thinking about how MAID-MI would realistically work in Atlantic Canada, participants envisioned HCPs as empowered, and patients disempowered:

> "…that profession that already has so much of a problem with under resourcing, under training, lack of basic empathy training in their schooling, even, giving them power over life and death is kind of already there. But legislating it to that point where it's literally like, you get to be God and recommend who dies? That's absurd." (Carmen)

For Carmen, the decision to die by MAID-MI is in the hands of the HCP, upon whom is bestowed the power of life and death, which they compare with the power of God. This contradicts common conceptualizations of dying by MAID as an autonomous choice (e.g., Dembo et al., 2018; Wiebe & Mullin, 2023). While it is true that such transfer of power could exist anywhere, participants emphasized that the absence of other options in Atlantic Canada creates significant room for subjectivity in the interpretation of "reasonable" and "available" options.

> "In New Brunswick, most of us don't have doctors, so majority of us don't have primary [care] – so you expect me to go into one meeting with someone, say, I want to die, and have them be able to be like, we can treat this person or we can't, when they have 20 other cases that they're dealing with just in that day. […] what's the difference between someone being like, this horrible thing is happening to me, and will they know the resources if someone's struggling if they're queer? They are unhoused. They are living in all these situations that makes life very difficult to live. Then are [doctors] going to be like, yeah, you should get MAID because it's too expensive otherwise for us to take care of you? Or are they going to say you're just suicidal because your living conditions suck? And then where do you go from there?" (P8 – queer, autistic, disabled)

In cases where treatments or interventions may be available but inaccessible, the HCP(s) tasked with assessing a request for MAID must determine what it means for an individual to have exhausted all "reasonable treatments [or interventions]" to relieve their suffering, as well as what it means for an individual to have "given serious consideration" to such treatments or interventions (*Model Practice*, 2023). As argued by Simpson (2017), this puts healthcare providers in a position to make "individual value judgments […] about which lives are worth living and which are not" (p. 82). Further, questions remain as to the nature and existence of a prior relationship between an HCP and a MAID-MI requestor. Currently, there is a lack of data on how many people who request MAID or died by MAID had access to a family doctor. Many participants expressed that to properly assess an individual for MAID-MI, the HCP would need a longstanding relationship with the individual and a strong understanding of their condition, treatment history, and social context – something difficult to obtain in Atlantic Canada, where psychiatrists are "precious resources" (P10) and "family doctors feel like a myth" (P14). Where

such a relationship didn't exist, participants envisioned that the process would reinforce existing power dynamics:

> "…it becomes like a pathological exercise where you have to get permission from people who already have a lot of power over you. And that sort of like having to justify […] the pain and the other things you're experiencing, and you're still not getting the supports you need, and now you're having to do that same thing, but to die. It just seems so fucked up to me." (P19 – queer, settler, disabled, middle-class)

P19's description of the process as "obtaining permission" once again indicates the transfer of "choice" from the individual to the provider. Further, P19 highlights the power dynamic that exists in the relationship between an individual and a HCP, which puts patients in a position of vulnerability to potential biases of HCPs (Mladenov & Dimitrova, 2023). One potential manifestation of HCP bias is through epistemic injustice:

> "I think you could see a lot of the same issues with MAID that we see for gender affirming healthcare assessments that healthcare providers are just like gatekeeping medical intervention because you present a certain way or communicate your ideas a certain way. […] people who are mentally ill, we constantly have our lived knowledge invalidated by healthcare professionals who say that they know better and that they're the experts, when in reality we are the ones who know what we need and want a lot of the time." (Riley – queer, transmasculine)

Epistemic injustice, wherein the credibility of an individual's knowledge is dismissed due to bias, is common in the field of psychiatry (Crichton et al., 2017), particularly for people with MI or who are otherwise disabled or marginalized. It is exemplified, along with ableism, in

arguments that transness arises from MI (e.g., Amos, 2024) and in withholding gender-affirming care from trans people with MI (e.g., Dewey & Gesbeck, 2017). Such practices inherently invalidate the knowledge and experiences of trans people through reinforcement of the belief that mentally ill people are not reliable to know their own experiences (Cavar & Baril, 2021; Wall et al., 2023).

> "At the end of the day, everything about queer and transness was always defined under the confines of psychiatry. Psychiatry saw homosexuality and gender dysphoria as mental illnesses until very, very recently. And that in and of itself means that psychiatry was designed to categorize behaviors as abnormal. Like we think about the example of drapetomania. I just don't think that we can trust MAID, or psychiatry in general to be making these major decisions about our bodies for us." (P29)

P29 conceptualizes psychiatry as a system that will be making "major decisions" for queer and trans people through MAID-MI, not as a system that will afford bodily autonomy through MAID-MI. It is true that 2S/LGBTQ+ communities have faced an extensive history of pathologization and psychiatrization, with queerness and transness framed as issues that need to be cured or solved (Smith, 2012). The desire to "fix" queerness or transness is a factor that some participants worried would be implicated in HCP's decisions to approve or reject an individual's request for MAID-MI:

> "…my biggest worry is just how they're going to go about dysphoria, pathologizing it and making it like a reason for opting for MAID. I'm worried that it's going to almost take precedence. It's like, oh, this person's extremely dysphoric, like, you deserve it more kind of thing." (P23)

> "…trans people are going to be saying these horrific things that happen in their life or like discrimination, or the dysphoria that they experience that makes them very depressed. […]. And [cis physicians are] going to look at that with the cis guilt and be like, […], yeah, society wasn't made for you. Sorry. I'm sorry, you're a marginalized person, yeah, you should kill yourself." (P18)

Demonstrated in these excerpts is fear of dysphoria and transness being painted with the same rhetoric that has long followed disability: a discourse of pity (Hughes, 2019), wherein the life of a person is perceived by the HCP to be so tragic that it would be "a merciful act" (Howdy) to end it. Following this narrative of pity and tragedy, we move to our final theme.

"An easier route to having less patients": Fearing coercive use of MAID

Alongside concerns about more subtle factors influencing who dies by MAID-MI in Atlantic Canada, participants also expressed concern about coercion or force – blatant elimination of an individuals' autonomy. Participants predicted this most often occurring in relation to, or as a solution to, the lack of resources in Atlantic Canada. Participants referenced recent cases (e.g., Seguin & Chisholm, 2023) of people in Atlantic Canada dying "in waiting rooms because we can't afford doctors" (Gordon) and "on stretchers in hallways because there just aren't any [hospital beds]" (P22) and worried that MAID-MI would become a way to "cut down on the numbers of people that are going to our hospitals" (P31). Others again emphasized the lack of family doctors, which has exorbitantly increased patient caseload for existing doctors and has decreased quality of care.

> "I also wouldn't be surprised if in a doctor's visit, someone was talking about their mental health issues and doctor is like, oh, have you thought of MAID? I could write

> your prescription right now, just to kind of end the appointment to get to the next person because I've got 15 people in the waiting room." (P7)

Some participants' concerns arose from what they have witnessed under existing MAID legislation:

> "…[friends are] getting referred to MAID all the time, and it's like they're having struggles with housing, they're having struggles with food, they have bedbugs, but they go to a clinician or they go to the publicly available resource, and they describe these cluster of symptoms and experiences and challenges, and the conversation goes to MAID." (P19)

> "…we have had patients tell us that before they were offered palliative care, they were offered MAID. And that's not supposed to happen. It is not supposed to work that way, but it does…" (P22 – Two-Spirit, disabled)

P22's account of what is "not supposed to happen" exemplifies the reality that despite efforts to regulate and enforce adherence, HCPs do not always operate under model standards of care – especially when working under nonideal conditions. The idea of a margin of error within MAID systems is controversial, with some proposing that "a small number of avoidable deaths" is justifiable in order to prevent suffering, whether that suffering stems from purely a MI, or from social conditions (Rooney et al., 2018, p. 330). This is challenged by others, who question how many avoidable deaths are tolerable (Sinyor & Schaffer, 2020).

In thinking of avoidable deaths, participants recognized the inequities that already exist in the healthcare system, and noted that MAID-MI would not be immune to the ways that healthcare oppresses marginalized populations. Participants contended that coercion or force would not

occur indiscriminately, but would be wielded against already marginalized and disempowered communities.

> "And I can only think of a practitioner who's like a doctor or something, is like looking at a chronic illness, like somebody who has a chronic illness and is like, constantly something they have to check in on and be present and like, the actual doctor and be present in their medical history, and then offering this as an option because they don't want to deal with this person anymore. […]. What's the point in actually caring for this person? Why don't you just try to nudge them to think about this, especially if you already, because you're ableist and live in a racist society, decide that they actually are kind of useless to a white supremacist society? It's like, I could see people who are very cruel or who, again, are just very logical in their perspective, would see it as something that they want to actually learn more about to get rid of some patients…" (P32)

Evident in this quote from P32 is recognition of pervasive ideals of usefulness, which they predict will influence who is offered MAID as an "option". In this ableist and capitalist framework that weighs the worth of individuals only in terms of their productivity and monetary value, those who cannot produce profit are imagined as "drains on public resources and therefore disabling to the nation writ large" (Schalk & Kim, 2020, p.44). This framework is also used to devalue the lives of the elderly (e.g., Parris, 2024); several participants brought up Atlantic Canada's aging population and lack of adequate long-term care, imagining "a few invisible hands […] pushing things in that direction " (P15), in reference to MAID-MI. Others feared that MAID-MI might be weaponized as "a solution to the houselessness problem" (Katherine), envisioning HCPs asking unhoused individuals "Have you ever thought about killing yourself?" (P7) or directly suggesting " yeah, you should kill yourself." (P3)

> "…the people who are gonna be impacted are people who have less access to other choices, who are racialized, marginalized on however many intersections. These are the people who are gonna - whose social workers, they're gonna say, hmm, have you considered MAID instead of therapy?" (P4 – Mad, queer)

Notably, multiple participants expressed concern specifically for Indigenous communities, worrying that MAID-MI could become "another form of ethnic cleansing" or "another byproduct of genocide" (Katherine).

> "And I should mention that in the Indigenous community, I mostly am scared less about people choosing it and more that it will be misused by the healthcare system. Because we have situations where doctors are sterilizing Indigenous women without their consent. What's stopping them from using MAID without their consent? Or like forcing it down their throats without really fully understanding their options? That's my biggest fear there. I can foresee it happening." (P22 – Two-Spirit, disabled)

P22 and Katherine's concerns derive from recognition of healthcare's role in systematically oppressing and eliminating populations, specifically Indigenous populations in Canada (Boyer, 2014; Clarke, 2021; Posca, 2020). Within a system where HCPs often mistreat Indigenous patients with relative impunity, participants feared that MAID-MI may become another tool in their arsenal.

Discussion

In this study, we explored the readiness of Atlantic Canada's healthcare system to implement MAID-MI, from the perspective of 2S/LGBTQ+ Atlantic Canadians with mood disorders. Participants overall expressed a lack of confidence in the system's capacity to implement MAID-

MI in a way that prioritizes autonomy. Specifically, they appraised the system as underresourced, overburdened, disempowering, and often incapable of providing patients with adequate care. Participants voiced concern that lack of treatment options and other life-affirming resources would push people towards MAID-MI; further, participants problematized the power the HCPs have in the MAID-MI process.

This study is one of few patient-centred and community-oriented studies on MAID-MI. The first was conducted in the Netherlands, where MAID-MI is legal, and interviewed only individuals with MI who wanted to die by MAID (Pronk et al., 2022). A recent study in Ontario, Canada investigated how people with MI and their family members felt about MAID-MI and explored their perspectives on how MAID-MI *should* be implemented (Bastidas-Bilbao et al., 2023). Some recommendations included more public education around MAID-MI and sensitivity in approaching the subject with patients. Also emphasized was the importance of a highly trained assessment team with extensive knowledge of the patient's social context and history; reflected in this is our participants' concern that individuals in Atlantic Canada will not have access to expert assessors who know them well. While it is important to seek the recommendations of people with lived experience on how best to implement MAID-MI, it is also important to consider the realities of healthcare systems in Canada and to identify areas where system failure might impact individuals' ability to make autonomous decisions about MAID-MI.

Regularly, concerns about autonomy (or lack thereof) in the context of people with MI are dismissed as paternalism, under the assumption that such concerns are centred around the idea that mentally ill people cannot make rational choices (e.g., Bahji & Delva, 2022). Proponents of MAID-MI argue that it is discriminatory to presume that people with MI do not have the capacity to consent to MAID-MI, and that doing so infringes upon their autonomy. Participants

similarly expressed concern about being denied autonomy in this way, specifically referencing discriminatory beliefs that trans people are confused or incapable of knowing themselves. Because withholding MAID-MI is seen as an attack on autonomy, some perceive that granting access to MAID-MI is the pinnacle of protecting autonomy, even if MAID-MI is presented as the only available option. Such viewpoints argue that, providing that the individual has capacity to consent, choosing the only option available is still an autonomous choice (Wiebe & Mullin, 2023). However, participants in this study were also attuned to the contextual elements of autonomy. Within the context of Atlantic Canada, participants referred to MAID-MI as becoming the "only" option or the "best" option. This aligns with literature that prioritizes the idea of social or relational autonomy and problematizes equating capacity to consent with full autonomy (e.g., Beaudry, 2020). Drawing from a feminist relational understanding of autonomy, Beaudry explores how the oppression that marginalized people experience inherently restricts autonomy, and does so in a way that "[appears] justified within the logic of somatic oppression by the very structure of society, so that the harms they cause to the autonomy competency of certain people are not conceptualized as injustices" (p. 289). Beaudry argues that MAID, in its current form, depoliticizes and medicalizes suffering by providing a medicalized "solution" to suffering caused by social and cultural issues.

Like Beaudry, our participants recognized that factors restricting autonomy in Atlantic Canada's healthcare system are compounded for those who are multiply marginalized. Indeed, discussions of autonomy in the context of MAID-MI are necessarily situated in government systems and therefore cannot be divorced from the ways that these systems engage in necropolitics (Mbembe, 2003) by creating and maintaining conditions that debilitate already marginalized populations. The "slow violence" of debilitation occurs through existing in conditions that promote illness,

disease, and disability (including MI), and impede one's ability to thrive (Puar, 2017; Schalk & Kim, 2020). In Atlantic Canada, disability is concentrated in marginalized and largely racialized communities through things such as PEI's reliance on (and abuse of) racialized migrant workers (e.g., Bejan et al., 2021), environmental racism in African Nova Scotian and Mi'kmaw communities (e.g., Waldron, 2021), and deliberately unchecked racism in healthcare and justice systems (e.g., Hunt, 2020; Metallic, 2020). We can also identify "slow violence" in provincial governments' continuous refusal to invest in improving healthcare (e.g., Alam, 2024), insistence on adopting policies that increase burden on the healthcare system rather than lessen it (e.g., Ross, 2024), and closure of clinics that serve primarily 2S/LGBTQ+ patients (e.g., Cox, 2024), as well as in federal policies that keep disabled people entrenched in poverty (e.g., Barghiel, 2024).

A feminist-of-colour disability framework scrutinizes that which is "marketed as liberatory and progressive" (Schalk & Kim, 2020, p. 41) and warns against campaigns that "prioritize the attainment of legal rights" (Kim, 2017, p. 2) and perceive the law as a source of protection, liberation, and justice. Using this framework, we must critically examine the portrayal of legalizing MAID-MI as a source of freedom and autonomy for people with MI in allowing them to "alleviate [their] needless suffering" (Rooney et al., 2018, p. 334). Our participants voiced that much of their suffering was maintained, if not caused, by inadequate healthcare systems; is it liberatory to be offered, by the very system that has created the suffering, death to escape it? Schalk and Kim write that when healthcare systems are tasked with managing "the fallout of [slow violence] … violence and care often become inseparable" (p. 47). Indeed, it is often in times of high demand for public resources that the necropolitical underpinnings of public policy become evident. Davis (2021) writes that "any metric used for determining who should get

limited resources will inevitably be drawn into a eugenics sinkhole" (p. 138); as the slow violence of debilitation maintains populations with poor health that hold less value under capitalist ideals, such populations are easily marked as disposable – a necessary sacrifice to ease systemic burden and restore the health of the nation. Where suffering is caused or exacerbated by social conditions and MAID-MI is the only accessible "care" option, it is essential to take into account the relational aspects of autonomy and to consider to what populations death is being offered under the guise of healthcare and autonomy.

To our knowledge, this is the first study on MAID-MI prioritizing 2S/LGBTQ+ perspectives, as well as perspectives of Atlantic Canadian communities. Participants described overall systemic failure of the Atlantic Canadian healthcare system and expressed concern about introducing MAID-MI into such a dysfunctional system. Despite efforts to recruit a diverse population, our sample was still largely white and the 20-29 age range was overrepresented, particularly in the context of Atlantic Canada's aging population. Participating in the study required an email address and a reliable internet connection; this was likely a barrier to participation for some rural communities, as well as those who are unhoused or precariously housed. Given that issues of access to care are likely to heavily impact these communities, future research should emphasize collaboration and engagement with these communities in-person.

In 1996, bioethicist Susan Wolf wrote that conversations around MAID are "most often about a patient who does not exist – a patient with no gender, race, or insurance status" (Wolf, 1996). The results of this study suggest that similarly, such debates are most often about a healthcare system that does not exist – one with no flaws, biases, or historical context. It is evident that significant improvements must be made in Canada before March 2027 if MAID-MI is to be introduced in a way that is safe, equitable, and just.

Credit author statement

Jay Tang: Conceptualization, Methodology, Formal Analysis, Investigation, Writing (Original Draft), Writing (Review & Editing). **Simon Carroll**: Writing (Review & Editing), Supervision. **Nathan Lachowsky**: Conceptualization, Methodology, Writing (Review & Editing), Supervision, Funding Acquisition.

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Declaration of competing interests

Jay Tang, Simon Carroll, and Nathan Lachowsky declare that there is no conflict of interest.

Data availability

The authors do not have permission to share data.

Chapter 3: Additional Results

During analysis, I identified a second overarching theme, "*The system has absolutely nothing for us*", which did not directly address the research question posed in Chapter 2 and was thus not included in the draft manuscript. Within this overarching theme, I developed two sub-themes. The first sub-theme, "*I feel like burning everything down*", prioritizes the manifestation of strong emotions in participants' comments, most notably a widespread feeling of bitterness in response to the idea of legalizing MAID-MI within the current Atlantic Canadian healthcare system. In discussing the second sub-theme, "*We are all we have*", I highlight participants' reflections on community care and its importance, especially during healthcare crisis.

"I feel like burning everything down": Affective responses to MAID-MI [5]

In discussing crises of resources, widespread poverty, inability to access healthcare, and general crumbling structures of social support, participants expressed a range of negative emotions that centred around the feelings of being abandoned by the government. As Calliope said:

> "The reason why we have a government is so that it can take care of its people […] how can this beautiful, rich country not take care of its people?" (Calliope – queer, disabled)

Participants commonly voiced bitterness and disappointment about the resources being spent on implementation of MAID-MI rather than "literally anything else" (Howdy – trans, queer).

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[5] To emphasize, this theme should not be interpreted to indicate universal negative feelings about MAID-MI among the participants in this study; rather, it is meant to highlight the feelings of abandonment that arose from participants during discussions on MAID-MI.

> "We're not gonna address the other stuff? We're gonna focus on this thing? Like no family doctor, housing security, like all these things are higher up on the list for me. But we're like, no, let's talk about this, like let's make this an option before I can get a doctor. No. Unacceptable. Lazy." (P12 – genderqueer, disabled)

Many participants acknowledged that the government is not ignorant of the life-saving resources that could be funded for communities. Others commented on how the government often funds research to identify community needs, but fails to implement any of the findings; "…if you're gonna fund this research, I mean, why the fuck don't we use it?" (P26). P18 references specifically the countless hours of work that 2S/LGBTQ+ communities and researchers have put into identifying service gaps and making recommendations for improvements, only for all of that labour to be ignored, and for life-saving services to be neglected in favour of MAID-MI.

> "It feels like a government attack of being like, oh, no, we see you, but we see you in the worst way. We see your suffering. We see you're marginalized. Here's what we've come up with that could make things better for you. […]. It's a weird resigning to the fact that… it's a weird resigning that the government doesn't care, where it's like, oh, so we've presented you with all the evidence of the things we need and how we could improve this for the queer community or for the trans community, and how you could make our lives easier. Here's what you spent your time on, though." (P18 – trans man)

For P18, MAID-MI is a very concrete representation of the government's apathy towards 2S/LGBTQ+ communities.

Similarly, Jamie's anger stems from witnessing the decision to make life ending resources more accessible than life affirming resources, particularly within a social hierarchy that expressly manufactures desperate need for life affirming resource.

> "…I'm very concerned, based on what I see with just, like, a lack of tangible, life affirming resources, to then offer a life ending resource and to make it so that there's no, like, here are the ways that we're going to affirm your life before you end up in a place where you're accessing MAID. […] they make it so difficult - and by they, I mean, like, the, like, top 5% who control the wealth in this country, in particular in the Maritimes, they make it so difficult, and they funnel people into very difficult, volatile work environments where they break them, and then they blame them for being physically and emotionally disabled, that it's... It really feels like, oh, you've reached the end of your usefulness, now we're going to chuck you into the trash. And so, like, I'm mad about it, to be honest." (Jamie – queer, non-Black racialized)

Jamie's account of wealth and labor distribution in Atlantic Canada is demonstrative of how governments sustain a "disposable population ensnared as laborers-consigned-to-having-an-accident" (Puar, 2017, p. 64); in other words, those in power create conditions where laborers inevitably become disabled. Once such laborers are no longer productive, they are no longer seen as useful, and thus are discarded. The narrative of disposability mirrors the narrative of usefulness discussed briefly in Chapter 2, and evoked strong feelings in participants, many of whom felt that the prospect of implementing MAID-MI sent a "very clear" message about the government's perception of their worth.

Participants emphasized different facets of identity and community in discussing their displeasure. Some participants conceptualized this on a national level:

> "I think it's very clear to Atlantic Canadians that you know, in terms of like from a national standpoint, especially in like the conservative mindset, we've always been on the yoke, you know, we're not an income generator for the country, and therefore we're a

> burden, and therefore we don't deserve these services. We've done nothing to earn them. And like, I think there's some really lethal mentalities when combined with [MAID-MI]." (P12)

A sense of Atlantic Canadian identity, along with a desire to protect and care for fellow Atlantic Canadians, was plainly communicated when participants spoke about the feeling of being forgotten by the federal government. Participants felt that Atlantic Canada is often "dismissed as being kind of backwards" (P31) and that to the rest of the country "we don't matter, we don't exist" and "they do not care how long Atlantic Canada lasts" (Gordon).

Others felt this sense of abandonment in the context of the 2S/LGBTQ+ community, as expressed by P26 (queer, non-binary, neurodivergent):

> "Making it easier to be murdered by the government than to access gender affirming care, safe spaces, shelter, food. Like in that fact sheet - 90 days between your first assessment and receiving MAID. It takes years to get top surgery. It takes months to get referrals, to get hormone replacement therapy, like… Disposable. I mean, it sends a very clear and obvious message, and if you think about it for more than 10 seconds, I mean, it's very clear they would rather treat us like garbage than treat us like human beings." (P26 – queer, non-binary, neurodivergent)

P26's "us" refers to the trans community, and they express indignation about the timelines associated with getting gender affirming care in contrast to the proposed timelines associated with dying by MAID-MI. Similar to P18, they viewed this discrepancy as a deliberate choice made by the government regarding which services to prioritize.

For P22, their anger is grounded on behalf of people with MI, and particularly suicidal people:

> "I get pissed off because I think that this is tiptoeing - not even so much as tiptoeing as sprinting towards eugenics at this point. I feel like they're looking at mental illness as something, an inconvenience that the government just wants to get rid of. And they want to get rid of it by killing people rather than putting money into resources necessary to actually help folks. Because it feels like eugenics. It feels like being dismissed as because you are suicidal, we're just going to help you along and kill you rather than talk about why you deserve to live." (P22)

Their words convey a sense of injustice, and the understanding that this is not what should be happening; suicidal people should be getting support to live instead of encouragement to die. P22 also references MAID-MI as being a way for the government to save money by getting rid of the "inconvenience" of people with MI. The narrative of disabled people being a burden stems from racist and ableist ideologies that present marginalized populations as drains on the health of the economy (Schalk & Kim, 2020). In eliminating such populations or making them disappear, the government can maintain the façade that it takes care of its people (Giroux, 2006).

Similar sentiments were expressed by Carmen, who thought about MAID-MI as an encouragement to give up:

> "And I don't think about suicide as a giving up or anything, but this particular version of offering MAID for mental illness and for suicidal ideation feels like it's an encouragement, like, just give up looking for something to improve. We don't want you here. That kind of, very eugenics, you're a burden on society, we'll pay for you to die, but we won't pay for you to live better." (Carmen – queer, racialized, disabled)

Cost has indeed been a consideration in the legalization and expansion of MAID. A report released in 2017, seemingly ahead of its time, estimated that implementation of MAID in

Canada, for terminal illness only, would result in healthcare savings between $34.7 million and $138.8 million annually (Trachtenberg & Manns, 2017); a 2020 report examining the estimated costs of expanding MAID eligibility predicted that doing so would result in significant healthcare savings (Beauchamp et al., 2020). The idea of being disposed of for financial gain was put simply by P4:

> "And you know why? Because it's a one-time cost for you to die. And paying for you to live is an ongoing project." (P4 – Mad, queer)

Indeed, "those who are no longer capable of making a living… and who depend upon others for the most basic needs" (Giroux, 2006, p.187), those whose bodies (and/or minds) are "too disabled to be rehabilitated into [a] citizenship" of productivity (Puar, 2017, p.40), may soon be offered death as an alternative to care.

P8's reflections on the legalization of MAID-MI evoke a sense of inevitability, certainty, and sadness for the future:

> "It's going to disproportionately impact queer individuals. We are going to see people die and we're going to see people decide to die when there are things that could have been changed instead of introducing MAID" (P8 – queer, Autistic, disabled)

However, like many of the participants quoted in this section, underlying this sadness is a profound sense of care for their community. This leads us to the final theme.

"We are all we have": Community care and its complexities

Mutual aid and collective care have been essential to the survival of 2S/LGBTQ+ communities and disabled communities (e.g., England, 2022; Piepzna-Samarasinha, 2018; Rayside & Lindquist, 1992), and participants made clear that this continues to be the case in communities in Atlantic Canada. While feelings of abandonment and bitterness towards the

government were evident across the dataset, participants consistently voiced that through the failure of systems, community saved and sustained them:

> "I think a lot of strength and support is done through mutual aid. Like, the queer community looks after itself. What was I was reading? Like, nobody cares about us, so we care about us, […] we take care of our own." (P8)

One area of professional support that participants regularly identified as lacking was suicide prevention and crisis intervention. Participants also refuted narrow conceptualizations of suicide prevention, which traditionally focus on preventing the act of suicide itself, instead of preventing or reducing suicidality. They recalled instances of "non-traditional" suicide prevention, such as delivering meals, offering a couch to someone precariously housed, advocating for each other at doctor's appointments, and mutual aid.

> "We're there for each other, basically. We are each other's mental health support system." (P14 – Black, queer, disabled femme)

The majority of participants had also supported a community member through a crisis situation, and/or had been supported by a community member through a crisis situation following the inadequate responses of crisis lines or emergency rooms. In community, participants found more helpful and more calming reactions to their suicidality compared with the shame or toxic positivity they often experienced from HCPs:

> "The harm that you want to get away from isn't fake. And you're not wrong for being angry or wanting to get away from it […], even the moments where I've been, like, at my worst, the people who pulled me back from that were the ones who said, yeah, you're right, this does suck. You shouldn't have to live through this. But what if you stick

> around until you find out if that's going to change. Or if you can't find a good reason to live, why not just be curious about what happens next?" (Carmen)

Carmen emphasizes the significance of their community holding space for their suicidality instead of jumping in to try to "fix" the problem or engaging in carceral means of crisis intervention. Many participants relied solely on community support when they were acutely suicidal, fearing institutionalization or police-led "wellness checks" if they sought professional support. Often, participants emphasized the feeling of safety that exists within their communities, allowing them to be open about their suicidality without the fear of being institutionalized. In discussing sources of strength, P32 said the following:

> "I would say, like, the communities I've been being able to build, just building stronger relationships with Black queer folks who are also gender expansive and also Mad and neurodivergent. That's been the strength there, knowing that I actually am not alone in at least these ways and that there's spaces I can go where I can be like, I actually want to kill myself and nothing is going to - like, I'm not going to be in danger for being honest. And I can talk about the racial, like, how racism impacts that, my suicide, and not feel weird about bringing it up. And those are where my strengths are." (P32 – queer, Black, neurodivergent)

Largely, support and care networks were comprised of people who were all struggling similarly. In P32's case, they drew strength from being in community with people who had similar identities and experiences; in an environment where culturally competent care is especially difficult to access, as discussed in Chapter Two, community care held even more significance. When in community with other Black, queer, Mad, neurodivergent people, they could discuss

racism and suicidality without the worry of being met with further racism, microaggressions, ignorance, or hostility.

While participants found comfort and value in being able to share their experiences with people who intrinsically understood their struggles, this was also a source of sadness and fear.

> "I do feel like there are so many people who understand what I'm experiencing and people that I can reach out to, but [it's] also like heart wrenching, in that I know how many people are experiencing this and how many people are suffering and yet I can't be there for all of my friends that I want to be there because I'm not even at full capacity. So the people that can help, can't. People who do understand can't be there to understand, because they're experiencing the same thing." (Gordon – queer, white, disabled)

The sense of exhaustion in Gordon's comments is mirrored in the work of Leah Lakshmi Piepzna-Samarasinha, a disability justice organizer and writer, who writes about the intricacies and complexities of care networks among sick and disabled 2S/LGBTQ+ BIPOC. They stress that while they have been a part of revolutionary, life-saving care networks, "…community can be fucked and inadequate too. […]. The community is not a magic utopia" (Piepzna-Samarasinha, 2018, p. 24). When struggling people need to rely on other struggling people with no external support, complications often arise – burnout, resentment, exacerbation of illnesses or disabilities, or often simply a lack of resources within the community to provide the care that is needed.

Community care networks are also not immune to the oppressive dynamics and desirability politics that exist in other spaces; privileged community members often benefit disproportionately from the labour of those who are racialized and/or femme, and people frequently need to "rely on being liked or loved to get care" (Piepzna-Samarasinha, 2018, p. 24).

Considering how these intra-community dynamics impact an individual's level of support, P19 wondered how this might influence decisions around MAID-MI:

> "But then I think about the people who are described as assholes or who might just be not a joy to be around because of various reasons, whether something internal or external, and how if you don't have a community of support around you, and lots of burned bridges because of relational dynamics that are human, how are you funneled into certain things like MAID quicker? How is that decision maybe not resisted or even just cared for in that way, when you don't have people around you who love you and express that love in that way?" (P19 – queer, settler, disabled, middle-class)

Other participants brought up the challenges that come with supporting community while also navigating personal boundaries and safety:

> "And then you really have to like find that balance of like, how can I be close and support this person, while also not like throwing myself back in a space where I am unsafe and unhealthy? But then you feel really guilty for setting any sort of boundary, because you understand, like, how difficult it is to be in that space. So, it really creates a lot of, I don't want to say torment, but like it can fracture a community sense or isolate people…" (P17 – queer, chronically ill, neurodivergent)

It is clear that collective care is not perfect. Establishing and sustaining care networks takes physical and emotional labour; it takes time and resources and willingness to make mistakes and keep trying anyway. It is also clear that collective care is vital, particularly when government supports are inadequate. Community, participants noted, both saved lives and gave people a reason to keep living:

"I wouldn't jump on the offer of MAID, because I went for a nice walk with my friends yesterday, and it was really nice. Like, I would miss the little walks. I would miss the banter. I would miss the chitchat. I would genuinely miss my community." (P14)

"…at the end of the day, community is what is going to save your life." (P29)

Chapter 4 - Summary of findings and discussion

Overall, the image that 2S/LGBTQ+ Atlantic Canadian participants living with a mood disorder painted was of a healthcare system that has failed them and a government that has abandoned them. In Chapter Two, I explored participants' disenchantment with the healthcare system in Atlantic Canada, and lack of confidence in its ability to properly implement MAID-MI; drawing from their lived experiences, participants highlighted inequitable distribution of healthcare resources and struggled to imagine how MAID-MI would not similarly reflect these inequities. In the additional results of Chapter 3, I discussed participants' anger, burnout, feelings of abandonment, and the importance of collective care. In this chapter, I intend to highlight the significance of making space for these additional findings, and to subsequently draw from a feminist-of-colour disability framework and other disability justice-oriented frameworks to relate these findings with those reported in Chapter Two. I conclude this thesis with reflections on the strengths, limitations, and possible implications of this study.

Disabled people – particularly those who are racialized or otherwise multiply marginalized – are too often expected to perform perfect victimhood. We are expected to ask politely for our needs to be met and to show unfailing gratitude when they are; if we fail to do so, we risk being labelled ungrateful, entitled, uncooperative, unpleasant. In their book *Crip Negativity*, queer disability scholar J. Logan Smilges writes that feelings such as gratitude and optimism "can be weaponized against disabled people when they're presented as affective prerequisites for our liberation" (Smilges, 2023, p. 67). Within the narrative of pity briefly discussed in Chapter Two, grovelling and gratitude allow nondisabled people to continue understanding themselves as charitable for indulging basic access requests; this mindset is perpetuated within a society that frames the needs of disabled people as "special" or

"exceptional". Expressing discontentment about injustice makes complacent others aware of their privilege, and thus uncomfortable (Ahmed, 2023). When receiving life-sustaining care is sometimes contingent on one's social status or social capital, as earlier noted, it can be difficult or dangerous to always be the "killjoy" drawing attention to problems.

Throughout this project, participants and I had the opportunity to sit with each other in negativity, disappointment, anger, frustration, sadness, fear, or as Smilges describes, "feel our bad crip feelings cripply" (p. 66). When expressing our needs is seen as complaining and we are pressured to be outwardly grateful for even the smallest accommodations, we can start to internalize the idea that we don't deserve better than what we are given. However, in making space to feel and express anger and other "bad crip feelings", we can reveal and interrogate the injustice from which these emotions originate. While some participants did note that they were grateful for the healthcare they were able to access, it was in the sharing of negativity that participants could acknowledge that they deserve better. Though this theme was peripheral to the aim of the analysis in Chapter Two, I felt it was important to honour participants' expressions of crip negativity, and to reflect in my writing the space held for negativity in our interviews. Throughout the project, participants voiced that being given the space to express negativity and to explore traditionally "bad" feelings with someone who understood their broad experiences was cathartic. As a researcher and as a community member, I was also grateful to be able to sit within community in this way.

It is important to note that crip negativity is not equivalent to hopelessness or despair; rather, it "[allocates] us a spacetime to collectively mourn how much change is needed […] so that later on we can more conscientiously articulate the world as we want it (Smilges, 2023, p. 76). Smilges emphasizes that crip negativity is inherently a relational practice, and that it is when

expressing crip negativity in community that hope can emerge, tentatively and organically. We can see this reflected in excerpts from "*We take care of our own*", where participants felt comfort in being able to discuss topics like suicidality and racism without being shamed for being a "killjoy" and without expectation or pressure to "fix" their "bad" feelings for others' comfort. We can also see that, while participants were deeply grateful for their communities, there was also a sense of bitterness surrounding the extent to which people need to rely on community due to systemic failures, along with sadness about the limited capacity within communities, and the inability to provide adequate care to everyone. It was important to report on "*We take care of our own*" to both highlight the injustices that lead to unsustainable reliance on community support, but equally to highlight and honour the essential role that community plays in keeping people cared for and alive. Neither of these additional themes can be decontextualized from the themes reported in Chapter Two; restrictions on autonomy, feelings of abandonment, and reliance on community care all originate from the systemic failures in Atlantic Canada's healthcare system. I will conclude this section with a reflection on autonomy and its relationship to disability and systems of oppression.

MAID-MI invites individuals to exercise their autonomy to end their suffering. Through expressions of crip negativity, participants problematized the idea of having "the autonomy to choose when you die, when you're being forced to it and not given the autonomy for anything else" (Carmen). As discussed in Chapter One, autonomy is a complex topic in the realms of healthcare and disability. Historically, the label of "disability" has been used as a means of control to restrict the autonomy of those who are marked as disabled by systems of power – capitalism, white supremacy, ableism, and heteropatriarchy. Non-whiteness, and specifically Blackness, has been associated with disability; consider, for example, the invention of

drapetomania, a mental disorder characterized by "the Black desire for freedom" (Bailey & Mobley, 2019, p. 25). In Canada, Indigenous women were disproportionately labelled as "mentally defective" in order to be forcibly sterilized under Sexual Sterilization Acts (e.g., Clarke, 2021) and Indigenous women have been forcibly sterilized by medical professionals as recently as 2019 (Basile & Bouchard, 2022). Homosexuality was pathologized as a disorder in the DSM until 1973; a year later, gender identity disorder was added to the DSM, allowing for medical professionals to see trans people as inherently abnormal, unhealthy, and deviant (Puar, 2017). Fatness is consistently medicalized and pathologized, with fatphobia itself entrenched in ableism and anti-Blackness (Mollow, 2017). Disability is wielded as a weapon against bodyminds that are deemed to be nonnormative – those that are Black, Indigenous, non-white, trans, queer, fat, or otherwise deviant. Agency and autonomy have, thus, long been withheld from marginalized communities. Some claim that restrictions on MAID-MI are a similar attack on the autonomy of marginalized people, and justify their staunch support for MAID-MI as defending human rights. This viewpoint, as discussed in Chapter Two, perpetuates both a very narrow understanding of autonomy as a concept and a very decontextualized understanding of MAID-MI.

In discussing activism around disability, it is essential to differentiate disability *rights* movements and disability *justice* movements. Disability *rights* movements, though they have contributed immensely to improving the lives of people with disabilities, center whiteness and privilege; "…the disability rights framework centers people who can achieve status, power and access through a legal or rights-based framework, which we know is not possible for many disabled people" (Sins Invalid, 2019, p. 8). Similarly, Black disability scholars Moya Bailey and Izetta Mobley (2019) assert that activism led by white disabled people who are otherwise

privileged is most often motivated by the desire to "access the full power" of their whiteness and their privilege, which is "their birth right" (p. 27). In other words, such activism works to restore the privilege of those who would otherwise be at the top of the social hierarchy, if not for their disability. It prioritizes the understanding of disability as something that is exceptional and accidental – an incidental misfortune. It therefore tends to leave behind those for whom disability is the norm, rather than the exception: those whose disabilities arise from chronic debilitating conditions (Puar, 2017).

Disability justice, on the other hand, is a fundamentally intersectional movement that precedes and informs feminist-of-colour disability studies. With the recognition that disability cannot be decontextualized from its existence in a capitalist, white supremacist, cisheteropatriarchy, it situates itself in ten grounding principles: intersectionality, leadership of the most impacted, anti-capitalist politics, cross-movement solidarity, recognizing wholeness, sustainability, commitment to cross-disability solidarity, interdependence, collective access, and collective liberation (Sins Invalid, 2019). In its commitment to prioritize leadership of the most impacted, disability justice inherently resists the tendency of disability rights to neglect those with less privilege; since the movement began, it has been consistently led by racialized and/or 2S/LGBTQ+ disabled people. Further, it resists seeking liberation solely through inclusion or through legal rights. Instead of "simply [joining] the ranks of the privileged", disability justice advocates seek to "dismantle those ranks and the systems that maintain them" (Mingus, 2011).

Disability rights and disability justice often diverge in their activism. Puar (2017) writes that unlike disability rights, disability justice activism "does not remain at […] soliciting tolerance, acceptance, and empowerment – but rather directs attention to the debilitating conditions of the medical-industrial complex itself" (p. 16). Considering this, it is worthwhile

examining who is fighting for the autonomy to choose MAID-MI, and who is fighting for the autonomy to choose life-sustaining resources. Though many who call themselves disability rights activists do advocate for and support MAID-MI, Dr. Catherine Frazee, professor emerita in the School of Disability Studies at Toronto Metropolitan University, writes that MAID proponents are overwhelmingly "white, wealthy, and worried about losing their social status if and when their lives are overtaken by disability" (Wilt, 2022). For example, Dying with Dignity Canada, an organization led predominantly by white people who hold high status academic jobs, has been a central proponent of advancing the right to MAID in Canada since the 1980s. In her book *Black Disability Politics,* Schalk cautions that white-led advocacy often "leaves Black, racialized, poor, and other multiply marginalized experiences of disability unaccounted for and excluded from disability rights political work" (p. 133); it is important to examine whose experiences of disability are being prioritized by those advocating for expanded access to MAID.

In contrast, many of those opposing MAID expansions are those who are still fighting to be able to access the resources they need to live, for example: Gabrielle Peters, a disabled policy analyst living in economic precarity who has been offered MAID before being offered care (Peters, 2024); or Indigenous Disability Canada/British Columbia Aboriginal Network on Disability Society, an organization supporting Indigenous people with disabilities, who experience the debilitating intersecting impacts of ableism, racism, and colonialism (Chown, 2024). Indeed, as those who are privileged advocate for the autonomy to choose death instead of treatment, they abandon those who have not yet been afforded the autonomy to access treatment in the first place. Puar (2017) calls for us "to ask who is able to participate in empowerment discourse and practices and why" (p. 67). The principles of disability justice call for the

leadership of the most impacted. In the case of MAID-MI, who has the least autonomy to choose to live? On whose lives is disability enforced and maintained?

In this study, participants described how disability is disproportionately created and maintained in Atlantic Canada due to systemic factors, and how this subsequently impacts the autonomy to choose MAID-MI. Discriminatory or ignorant HCPs and inability to access gender-affirming care exacerbate MI in 2S/LGBTQ+ individuals, particularly trans individuals. Racism, in both the broader community and in healthcare, restricts racialized individuals' ability to safely access care. Where quality mental health care exists, it is often prohibitively expensive, and people lacking financial privilege are trapped in the purgatory of endless wait lists. People living rurally face the barrier of needing to travel for medical care. Of course, these barriers are not mutually exclusive; as marginalization compounds, ability to access safe and effective care decreases. Further, the cycle perpetuates itself: people who are already struggling become "much more disabled, even like chronically and forever, because of the effects of illness that goes untreated or undiagnosed" (P17).

To conclude, I emphasize that it is unjust, and unjustifiable, to decontextualize MAID-MI from the social reality in which it is situated. Discussions on autonomy must consider not only the autonomy to choose MAID-MI, but the autonomy to choose other options, and these discussions must be led by those who are most impacted: those whose autonomy is withheld by way of inaccessible or nonexistent life-sustaining resources.

Strengths and limitations

This study had several strengths. It engaged a population that has largely been absent from research, and it benefited from collaboration with community advisors as well as previously established community relationships. Anecdotally, many participants expressed that they were

excited about the research as they felt that the community in Atlantic Canada was often forgotten or excluded. Some participants also acknowledged and appreciated the ethical considerations that were in place, particularly the counsellor debrief, and the opportunities to self-identify and indicate preferred language in terms of both identity and MI. My position as an "insider" in the community of interest allowed me to establish strong rapport with participants and gain a deeper understanding of their perspectives.

This study also benefitted from the use of a feminist-of-colour disability framework that emphasized intersectionality and the impact of mutually constitutive systems of oppression. While the social determinants of mental health and the impact of structural vulnerability have been noted in theoretical work on MAID-MI (e.g., Gaind et al., 2022; Ho & Norman, 2019), empirical research on MAID-MI has thus far failed to foreground intersectionality. Further, there was strong methodological coherence between my chosen methodology, theoretical framework, and analytic approach. Both interpretive description and reflexive thematic analysis acknowledge the importance of researcher knowledge and subjectivity, resisting the problematization of insider research. Following the methodology of interpretive description, the goal of analysis was not to fit the data into the chosen theoretical framework, but to position data in dialogue with theory in such a way that honors the complexity of participants' experiences. A feminist-of-colour disability framework provided a lens through which to further explore this complexity and enhanced understanding of the structural issues that both impact participant experiences and may complicate efforts to utilize this research for applied purposes such as policy change.

Despite efforts to recruit a diverse population, our sample was still largely white and the 20-29 age range was overrepresented, especially in the context of Atlantic Canada's aging population. As noted by some participants, 2S/LGBTQ+ older adults may be at higher risk of

MAID-MI coercion or abuse due the inadequate structure of long-term care in Atlantic Canada – particularly for 2S/LGBTQ+ older adults – along with ableist rhetoric that devalues older community members; it is also important to understand this populations' unique needs surrounding MAID-MI. There were also aspects inherent to the project that decreased its accessibility for some populations. Though some recruitment occurred through word-of-mouth, physical posters, and public radio, the majority of recruitment occurred online or through email lists, which was likely less effective in reaching older populations. Additionally, signing up for and participating in the study required an email address and a reliable internet connection; this is a barrier to participation for those without internet access, access to a computer, or access to a private computer, including some rural communities, as well as those who are unhoused or precariously housed. Given that issues of access to care are likely to impact these communities more heavily, future research should emphasize collaboration and engagement with these communities in-person.

Future directions

Due to the range of topics explored in this study, there is ample opportunity for continued analysis with this dataset. Of note, in our interviews we discussed participants' conceptualizations of the relationship between suicide and MAID-MI. While there does exist a body of literature examining this relationship, it is largely (if not entirely) centred on the perspectives of HCPs. This topic warrants further analysis, considering that suicidality is one of the main topics of ethical debate around MAID-MI. Additionally, participants were asked to provide recommendations for a MAID-MI policy that prioritized the needs of 2S/LGBTQ+ communities and other communities important to them. These results will be analysed in the future and used to inform advocacy efforts.

There are significant possibilities for applied and practical implications for this research. Given that legalization of MAID-MI is not set to occur until 2027, these next years are crucial for intervention and action. It is first important to increase awareness and understanding of MAID-MI and its implications within the 2S/LGBTQ+ community; to date, there has been little engagement of 2S/LGBTQ+ organizations and/or leaders on the topic of MAID-MI, despite its relevance to the community. Suicide prevention has long been a priority in the 2S/LGBTQ+ community (e.g., Ferlatte et al., 2021), and there is critical need for discussion on the complexity of navigating suicide prevention alongside MAID-MI. The results of this research also highlight areas of healthcare system failure that have detrimental impacts on 2S/LGBTQ+ Atlantic Canadians' physical and mental wellbeing, and that will complicate MAID-MI implementation. To make positive change in these areas will require systemic action on the part of provincial and federal governments. Mobilizing this research through various channels, such as HCP networks and associations, 2S/LGBTQ+ advocacy organizations, and media, may create opportunities to put pressure on governments to address issues.

Outside of the current study, there remain many populations whose voices have been excluded from conversations around MAID-MI, and there is urgent need to engage with these populations. Such populations include currently and formerly incarcerated people, unhoused and precariously housed people, people living in Northern Indigenous communities, people living in long-term care, and disabled people who are or have been institutionalized. As noted earlier, it is essential to foreground those whose autonomy to live is most heavily restricted and to examine MAID-MI within an intersectional social context; by discussing MAID-MI decontextualized from the structural and systemic factors that create and perpetuate disability, we only continue to mask injustice.

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Appendix A – Certificate of ethics approval

University of Victoria
Office of Research Services | Human Research Ethics Board
Michael Williams Building Rm B202 PO Box 1700 STN CSC Victoria BC V8W 2Y2 Canada
T 250-472-4545 | F 250-721-8960 | uvic.ca/research | ethics@uvic.ca

Certificate of Approval

PRINCIPAL INVESTIGATOR:	**Nathan Lachowsky** (Supervisor)	**ETHICS PROTOCOL NUMBER** Board member review - delegated	**23-0253**
PRINCIPAL APPLICANT:	**Jay Tang** **Master's student**	ORIGINAL APPROVAL DATE:	19-Jan-2024
UVIC DEPARTMENT:	**Public Health and Social Policy PHSP**	APPROVED ON:	19-Jan-2024
		APPROVAL EXPIRY DATE:	18-Jan-2025

PROJECT TITLE: **Medical assistance in dying and mental illness: Perspectives from 2S/LGBTQ+ individuals in Atlantic Canada**

RESEARCH TEAM MEMBERS:
Simon Carroll - Co-Supervisor, UVic
Brittany Jakubiec - Co-investigator, Egale Canada
Aine Humble - Co-investigator, MSVU
Katelin Albert - Co-investigator, UVic

DECLARED PROJECT FUNDING:
Social Sciences and Humanities Research Council (SSHRC), University of Victoria

DOCUMENTS INCLUDED IN THIS APPROVAL:
tcps2_core_certificate_JT.pdf - 24-May-2023
TrainingCertificates_JT.pdf - 07-Jun-2023
InitialSurvey_v4.pdf - 16-Jan-2024
RecruitmentAd_v2.pdf - 16-Jan-2024
DemographicsAccessConsent_v5.pdf - 16-Jan-2024
InterviewQuestions_v3.pdf - 16-Jan-2024
MAIDFactSheet_v1.pdf - 16-Jan-2024
ParticipantResources_v2.pdf - 16-Jan-2024
GroundingStrategies.pdf - 16-Jan-2024
TranscriptReview.pdf - 16-Jan-2024

Conditions of approval

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Amendments
To make changes to the approved research procedure in your study, please submit "Amendments" or "Annual renewal with amendments" form. You must receive research ethics approval before proceeding with your amended protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria's policies for research involving human participants.

[redacted]

Dr. Sandra Gibbons
Chair, Human Research Ethics Board

Dr. Matthew Murphy
Vice-chair, Human Research Ethics Board

Certificate Issued On: 19-Jan-2024

Appendix B – Recruitment materials

Text for email blasts:

Jay Tang (they/them), a graduate student in the Social Dimensions of Health Department at the University of Victoria, is seeking individuals to participate in a study about 2S/LGBTQ+ identity and medical assistance in dying (MAID) for mental illness. Individuals are eligible for this study if they fill the following criteria:

- Are 19 years of age or older
- Identify as 2S/LGBTQ+
- Currently have a mood disorder (e.g., depression, bipolar, dysthymia/persistent depressive disorder), whether professionally diagnosed or not
- Have some knowledge of MAID in Canada
- Have lived in Atlantic Canada for at least 5 years (past or present)
- Are able to communicate and understand English
- Are eligible for federally/provincially-funded health services in Canada
- Are currently living in Canada

To apply to participate, please fill out a brief survey (https://www.surveymonkey.ca/r/MAIDstudy). If you are eligible, you will be contacted by email to set up an interview. Interviews will be conducted by a queer and trans individual from PEI and will take place over Zoom, through either an audio/video call or through live chat.

If you have any questions or would like more information, please email tangjs@uvic.ca.

This study is being conducted by Jay Tang (graduate student, UVic), supervised by Dr. Nathan Lachowsky (Associate Professor, UVic), in collaboration with Mount Saint University and Egale Canada. It is funded under a SSHRC Partnership Engage Grant.

THIS STUDY IS BEING CONDUCTED BY JAY TANG (GRADUATE STUDENT, UVIC), SUPERVISED BY DR. NATHAN LACHOWSKY (ASSOCIATE PROFESSOR, UVIC), IN COLLABORATION WITH MOUNT SAINT VINCENT UNIVERSITY AND EGALE CANADA. IT IS FUNDED UNDER A SSHRC PARTNERSHIP ENGAGE GRANT.

Appendix C – Initial screening survey

Interest in 2S/LGBTQ+ Atlantic Canada MAID Study

Thank you for your interest in participating in this study. Please read the following information:

This study seeks to explore the perspectives of 2S/LGBTQ+ Atlantic Canadians with mood disorders regarding medical assistance in dying for mental illness (MAID-MI). Participants will take part in a semi-structured interview with me (Jay Tang) to discuss 2S/LGBTQ+ identity, mental illness, and opinions on MAID-MI. During the interviews, it is possible that distressing topics such as suicide, suicidal ideation, and discrimination may come up. Those who are eligible to participate will be sent more information on the types of questions that will be asked and the safeguards in place for both myself and the participants.

If you are interested in participating, please fill out this form. All information collected in this form will be kept confidential and will only be used by me (Jay Tang) to confirm your eligibility for this study or to contact you.

If you are not eligible for the study, you will not be contacted and your data will be destroyed. If you are eligible and selected for this study, I will contact you by email.

Thank you!

Jay (they/them)

Preferred name:

Pronouns:

Contact email:

To ensure that you are eligible to participate in this study, I need the following information.

Are you 19 years of age or older?

- o Yes
- o No

Do you identify as 2S/LGBTQ+?

- o Yes
- o No

Are you currently living in Canada?

- o Yes
- o No

Have you lived in Atlantic Canada (New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island) for at least 5 years? You do not need to be currently living in Atlantic Canada.

- Yes
- No

Are you able to communicate and understand English?

- Yes
- No

Are you eligible for federally/provincially funded health services? Canadian citizens and permanent residents are eligible for federally/provincially funded health services.

- Yes
- No

Do you currently have a mood disorder? Common mood disorders are depression, bipolar, and dysthymia/persistent depressive disorder.

We recognize that medical categorizations are not always reflective of individuals' lived experiences, especially for those who may be BIPOC, 2S/LGBTQ+, or otherwise marginalized. We also recognize that there are many barriers to receiving a professional diagnosis. For the purposes of this study, we are defining "mood disorder" as a disorder that causes disruption in your mood. If you feel that you have a mood disorder based on this definition, regardless of whether or not you have a formal diagnosis, please check "Yes".

Your eligibility is not impacted if you have additional illnesses, disabilities, or conditions, alongside a mood disorder.

- Yes
- No

What mood disorder(s) do you have? Select all that apply.

If you feel that you have (a) mood disorder(s) based on our definition, but do not identify with a typical named mood disorder, please select "Other" and provide a brief description.

- Depression
- Bipolar disorder
- Dysthymia/persistent depressive disorder
- Other (please specify)

Do you have some knowledge of MAID in Canada?

- Yes

- No

What do you know about MAID in Canada? A sentence or two is fine.

_____

True or false: Currently, MAID is available to those in Canada with a terminal physical illness (someone whose natural death would occur reasonably soon) AND those with a non-terminal physical illness (someone whose natural death would not occur reasonably soon).

- True
- False

True or false: In March 2024, MAID will be available to those in Canada with solely a mental illness (i.e., those with no additional underlying physical illnesses).

- True
- False

Are there any other ways that you would like to self-identify? This could include disability (including neurodivergence, other mental illnesses, physical disabilities, etc.), body size, socioeconomic position, rurality, or other aspects of identity or experiences. We are asking this question in order to ensure a diversity of perspectives is reflected within this project.

_____

Appendix D – Demographics, Accessibility, Consent questionnaire

Thank you for your interest in this study!

This study seeks to explore the perspectives of 2S/LGBTQ+ Atlantic Canadians with mood disorders regarding MAID for mental illness. Participants will take part in a semi-structured interview with me (Jay Tang) to discuss 2S/LGBTQ+ identity, mental illness, and opinions on MAID-MI. During the interviews, it is possible that distressing topics such as suicide, suicidal ideation, and discrimination may come up. You should have already received a copy of the interview questions. *If you have not received a copy of the interview questions, please email tangjs@uvic.ca before proceeding with this questionnaire.*

Preferred name:

Pronouns:

Contact email:

Part I: Informed consent form

Title of study	Medical assistance in dying and mental illness: Perspectives from 2S/LGBTQ+ individuals in Atlantic Canada
Supervisors	Dr. Nathan Lachowsky, University of Victoria Dr. Simon Carroll, University of Victoria
Researcher	Jay Tang

Participation in this study requires reading and understanding of this consent form. Please read it carefully in its entirety and do not hesitate to ask any questions should you need clarification. If you have questions, please email tangjs@uvic.ca.

Jay Tang (they/them), who will be conducting the interviews, is a queer and trans POC from Prince Edward Island with professional, personal, and activist experience working with the 2S/LGBTQ+ community. They have a BSc in Biology and Psychology and are currently pursuing an MSc in Social Dimensions of Health. This study is being conducted by Jay at the University of Victoria as part of the requirements for this degree.

The data collected in this study will be used by Jay to fulfill the requirements of their Master's program. The results of this research may additionally be shared through conference presentations; published articles, chapters, or books; research reports; and media.

This study is funded under a SSHRC (Social Sciences and Humanities Research Council) Partnership Engage Grant and is being conducted in collaboration with the University of Victoria, Mount Saint Vincent University, and Egale Canada.

WHAT IS THE PROJECT ABOUT?

You are being invited to participate in a study that seeks to explore marginalization, identity, and perspectives on medical assistance in dying for mental illness (MAID-MI) among a population of 2S/LGBTQ+ Atlantic Canadians with mental illness. The goal is to understand and highlight diverse voices from a population that will likely be affected by the upcoming legalization of MAID-MI in Canada.

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE RESEARCH DURING MY PARTICIPATION?

If you have any questions or desire further information, you can contact Jay at tangjs@uvic.ca.

WHO DO I CONTACT IF I HAVE ANY CONCERNS OR COMPLAINTS ABOUT HOW THIS RESEARCH IS BEING CONDUCTED?

If you have any concerns or complaints with respect to your participation in this research, please contact the University of Victoria Human Research Ethics Board at ethics@uvic.ca or 250-472-4545.

This study has been reviewed by the University of Victoria Human Research Ethics Board. The University of Victoria Human Research Ethics Board is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them.

WHAT WILL PARTICIPATION INVOLVE?

The main aspect of participation is an interview, taking place in the format that is most accessible to you as indicated by you in this form. Interviews will take approximately 1-2 hours and will be recorded and transcribed. During the interview, you will be asked questions about your perspectives on MAID-MI, how you conceptualize your identity, and your experiences of marginalization. Because this is a semi-structured interview, other topics may also arise during conversation. You will be e-transferred $50 for participating in the interview. If you do not use online banking/cannot accept e-transfers, you can choose an option at https://www.paypal.com/ca/gifts/all and will be emailed an online gift card of a $50 value.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

MAID-MI is a complex and difficult topic, and due to the open-ended nature of the questions and the interviews, there is a possibility for additional sensitive topics to arise, including but not limited to trauma and discrimination. There are three questions that inquire generally about the topic of suicide. *You will not be asked about your specific experiences with suicidality.*

These topics can be upsetting or uncomfortable to discuss, and may elicit difficult emotions. You will be provided a copy of the interview guide prior to beginning the interview and are encouraged to let Jay know if there are any questions that you do not want to answer, as well as any specific topics that you would like to avoid during the interview. *You are also able to decline responding to any questions during the interview, and you are welcome and encouraged to take breaks throughout the interview.*

WHAT INFORMATION WILL BE KEPT PRIVATE?

Your interview will be audio recorded and our discussion will be transcribed word for word so that important themes can be identified. When the interview is transcribed, all identifying information (including your name, and names of other people, specific locations, businesses, hospitals, schools, etc.) will be removed. We may use direct quotes from you, but they will be de-identified and will be attributed to either a pseudonym (fake name) or participant number. All the information you share is confidential. Only members of the research team will have access to the information from the interview. Your identity will be protected and all information that is recorded, transcribed and analyzed will be stored in a password-protected folder on the University of Victoria cloud server. The UVic-licensed versions of Zoom and SurveyMonkey will be utilized, so all data will be retained in Canada.

Data with personal identifying information of participants will be destroyed three months after project completion. All raw data (audio files/Zoom chat logs) will be kept for up to seven years after project completion (*anticipated* December 2024), in line with UVic's Scholarly Integrity Policy. After this time, files will be destroyed by permanently deleting the files from the University of Victoria server. Personal notes and de-identified transcripts will be kept indefinitely, for use in publications and presentations about this project. The data that is kept indefinitely will include no identifying information, and will be secured in a password-protected folder on Jay's OneDrive, which is password-protected with multi-factor authentication enabled.

CAN I WITHDRAW FROM THE INTERVIEW?

Participation is voluntary and you may withdraw at any point during the interview. You may also refuse to answer any questions you do not want to answer, or ask that your data be withdrawn from the study after the interview has taken place. If you withdraw at any point during the interview, or withdraw your data after the interview has taken place, *you will not be required to refund the honoraria.*

FUTURE USE OF DATA

The data collected in this study may be used in future solely by Jay, for such purposes as PhD work and related conference presentations; published articles, chapters, or books; research reports; and media. If it is used for such purposes, all information above regarding privacy and confidentiality will remain true.

You may request for your data to be destroyed or withdrawn from the study by contacting

tangjs@uvic.ca at any point until three months after project completion *(anticipated* December 2024), at which point information linking data to specific participants will be destroyed and we will therefore be unable to withdraw data linked to a specific participant.

By checking "Yes" below, you agree to the following:

- You have read and understand the information about this study.
- You understand what you will be doing in this study and consent to participate.
- You understand that you are free to withdraw consent at any time.
- You understand the possible risks of participating in this study.

Checking "Yes" below and submitting this survey constitutes consent and implies your agreement to the above statements.

If you do not consent, exit this survey. Your data will be destroyed.

- o Yes

Additionally, I want to ensure I interpret your data in a way that is true to your perspectives and experiences, and I will therefore ask your consent to recontact you twice in the future. Although recontact is optional, it is an important and valuable part of our research process.

Transcript review: After I have transcribed your interview, I would like to send you a copy of the transcript (with all identifying information removed) via email for you to review. This is for you to ensure that I have transcribed what you have said accurately. When I email you the transcript, the file will be password-protected to ensure your privacy. This is entirely voluntary, and if you do not wish to take part, there will be no negative consequences. There is no compensation for participating in transcript review. If you do not wish to participate in transcript review, respond "no" to the related question below.

Do you wish to participate in transcript review?

Preliminary analysis review: After completing initial analyses of the interviews, I want you to have the opportunity to review the analysis. These will not be results from your personal interview, but rather overall themes and concepts we have identified from analyzing the interviews in aggregate. Again, I want to ensure I interpret your data in a way that is true to your perspectives and experiences, and I will ask for feedback regarding any incorrect conclusions. This review can take place over email or Zoom, and I will incorporate your feedback, along with the feedback of the other participants, to the best of my ability. This is entirely voluntary, and if you do not wish to take part, there will be no negative consequences. There is no compensation for participating in analysis review. If you do not wish to participate in analysis review, respond "no" to the related question below.

Do you wish to participate in analysis review?

Do you have any questions?

Part II: Demographics

All of this information will be kept confidential. It will only be used for the purposes of this project and will not be shared with others.

Age:

In what province or territory do you currently live?

- New Brunswick
- Nova Scotia
- Newfoundland
- Prince Edward Island
- Yukon
- Nunavut
- Northwest Territories
- Manitoba
- Saskatchewan
- Alberta
- British Columbia
- Ontario
- Quebec

Please indicate what Atlantic province(s) you lived in/currently live in

What is your race/ethnicity? Check all that apply

- Indigenous, First Nations, Metis, or Inuit
- Black
- East/Southeast Asian
- Latina/Latino/Latinx/Latine
- Middle Eastern
- South Asian
- White
- I prefer to self-identify as:

What is your gender identity? Select all that apply

- Agender
- Genderfluid
- Genderqueer
- Cisgender man
- Trans man

- Cisgender woman
- Trans woman
- Non-binary
- Transmasculine
- Transfeminine
- Two-Spirit
- Other (please specify)

What is your sexual orientation? Select all that apply

- Asexual
- Bisexual
- Gay
- Lesbian
- Pansexual
- Queer
- Questioning
- Straight
- Two-Spirit
- Other (please specify)

How would you describe your financial situation?

- Cannot make ends meet
- Have to cut back
- Enough, but no extra
- Comfortable, with extra

What mood disorder(s) do you have? Select all that apply.

As a reminder, for the purposes of this study, we are defining "mood disorder" as a disorder that causes disruption in your mood.

If you feel that you have (a) mood disorder(s) based on our definition, but do not identify with a typical named mood disorder, please select "Other" and provide a brief description.

- Depression
- Bipolar disorder
- Dysthymia/persistent depressive disorder
- Other (please specify)

Are there any other ways that you would like to self-identify? This could include disability (including neurodivergence, other mental illnesses, physical disabilities, etc.), body size, socioeconomic position, rurality, or other aspects of identity or experiences.

_____

During the interview, some questions will ask you to reflect on your identities. What language would you prefer that I use to refer to your identities? For example, I would ask to be referred to as “a queer, racialized, disabled person”

_____

During the interview, some questions will ask about living with a mood disorder. What language would you prefer that I use to refer to your mood disorder?

- Mood disorder
- Mental illness
- Depression
- Bipolar disorder
- Dysthymia
- Disability
- Other (please specify)

When the interview is transcribed, all identifying information (including your name, and names of other people, specific locations, businesses, hospitals, schools, etc.) will be removed.

For example, a sentence such as: "Me and my friend Jessica were discussing how difficult it is to access mental health support in Cornwall" would become: "Me and my friend [name] were discussing how difficult it is to access mental health support in [town]"

We may use direct quotes from you, but they will be de-identified and will be attributed to either a pseudonym (fake name) or by participant number. Would you prefer to be referred to by a pseudonym of your choosing, or by participant number?

- Participant number (e.g., Participant 4)
- Pseudonym (fake name) _____

In attributing quotes to you, we many use some descriptors to contextualize your experience.

For example: “My experience living in Atlantic Canada was not always positive.” – Jay (a queer, racialized, disabled person)

However, we recognize that due to the tight-knit nature of the 2S/LGBTQ+ community in Atlantic Canada, there is a possibility that such descriptors may make you identifiable. Please indicate here your preferences:

- I do not wish for descriptors to be used for quotes attributed to me
- Use the following descriptors for me: (for example, I would write: queer, racialized, disabled person). _____

Part III: Accessibility

I want to ensure that this study is accessible for any eligible participants who want to participate.

I will be collecting data through semi-structured interviews. This means that the interview will be loosely guided by pre-established questions but will not be restricted to these questions.

--

These are the available options for interviewing:

Zoom: 1-2 hour video/audio call. Live closed captioning will be available, but I am unfortunately unable to provide ASL interpretation. You will not be required to turn your camera on.

Live chat: If you would prefer to provide written answers rather than verbal answers, we can communicate via the chat function on Zoom. This will allow us to have a real-time dialogue.

Which of the following options are accessible to you? Check all that apply.

- Zoom
- Live chat

Please indicate your **preferred option** from the above question. _____

All participants will be given the opportunity to book one debrief session with a qualified counsellor, at no cost to you, within ten business days of the interview taking place. We are providing this option as we recognize that some people may prefer to take some time to process and reflect independently before debriefing. However, there is also the option to book a session immediately after your interview. If you feel that you would benefit from debriefing with a counsellor immediately following the interview OR later on the same day (for example, if you feel it is likely that the interview will bring up difficult emotions), please check "Yes" below. I will then be in contact with you to organize scheduling.

- Yes, I want to schedule a debrief *immediately after/on the same day as my interview***.**
- No (*you will still be able to book a debrief session,* but it will not be immediately after/same day).

(OPTIONAL) Provide the name and contact information for a support person that I can contact if needed (for example, if emotional distress occurs during the interview and you would like support). Providing information here indicates your consent that I may disclose your name, and your participation in this project, to this individual.

However, I will not contact this individual without you providing consent during the interview, and I will only contact them in the context of this study. I will not disclose to them any information you provide to me during the interview, unless you give explicit consent.

The information you provide here will be stored securely along with your data, and will be destroyed upon conclusion of the interview.

Name: _____

Email address: _____

Phone number: _____

After reviewing the interview guide, are there any questions/topics that you would like to avoid or skip? *As a reminder, I will give you another opportunity to identify questions/topics you'd like*

to avoid, and you are always free to skip questions or request to move on from a topic during the interview, with no justification required.

- There are no questions/topics that I want to avoid.
- Yes, I would like to avoid the following questions/topics: _____

Do you have any accessibility needs that would be helpful for me to be aware of to support your participation in this project?

_____

Is there any other information about you that you would like to share?

_____

Appendix E – Interview script

*note: where [insert identity] or [mental illness] are written, these were replaced with the term that each individual participant indicated in the Demographics/Accessibility/Consent questionnaire.

Part I: Identities

As you know, the main subject of this study is medical assistance in dying, or MAID, for mental illness, and I am interested in queer, mentally ill, Atlantic Canadian perspectives on it. However, I am also interested in how marginalization and identity impact, or interact with, perspectives on MAID. With that said, I am hoping to learn a bit more about your identity, and your experiences relating to your identity.

Tell me a bit about the identities that are important to you. This could be your race/ethnicity, your sexuality, your gender, your disability status, or anything else that is significant to you.

What was your experience navigating the world as a [insert identity] person in Atlantic Canada? This could be, for instance, experiences at school or work, experiences finding/creating your communities in Atlantic Canada, experiences within the broader Atlantic Canadian culture, or anything else you'd like to talk about.

Part of the criteria for participating in this study is that you have a mood disorder, whether professionally diagnosed or not. Could you tell me a bit about what living with a mood disorder means to you?

- As a [insert identity] person with a [mental illness], did you access/try to access any professional mental health supports in Atlantic Canada? What was your experience like?

What are the interactions between your [mental illness], your identities, and your experiences living in Atlantic Canada? Did they shape each other in any way?

What communities are important to you? These could be communities related to your sexuality, gender, race/ethnicity, hobbies/activities, etc.

- In your communities, do you ever talk about mental illness? If so, in what communities? What are your conversations like?

[*The next two questions will ask about suicide. As a reminder, you are welcome to skip these questions now or after you hear the questions. If you'd like, we can also take a break before proceeding.*]

- In your communities, do you ever talk about suicide? If so, in what communities? What are your conversations like?
    - As a [insert identity] person, how do you feel when thinking about suicide in your communities?

Part II: MAID for mental illness

As a person with a mental illness, how do you feel when thinking about MAID becoming an option for people with mental illness?

In your communities, do you ever talk about MAID? If so, in what communities? What are your conversations like?

- As a [insert identity] person, how do you feel when thinking about MAID becoming an option for the people in your communities? Are your feelings broadly negative or positive?
- How do you think the 2S/LGBTQ+ community will be impacted by the legalization of MAID for mental illness? What about the other communities that are important to you?
    - Do you think there are any factors specific to the 2S/LGBTQ+ community that will make 2S/LGBTQ+ individuals more or less likely to access MAID for mental illness?

[*The next question will ask about suicide. As a reminder, you are welcome to skip this question now or after you hear the question. If you'd like, we can also take a break before proceeding.*]

How do you conceptualize the relationship between suicide and MAID for mental illness?

How do you think your identities shape the way you think about MAID for mental illness?

- How do you think your experiences as an Atlantic Canadian shape the way you think about MAID for mental illness?

Thinking about Atlantic Canada specifically, do you have any concerns about how Atlantic Canadians will be impacted by the legalization of MAID for mental illness?

- Do you think there are any factors unique to Atlantic Canada that will make Atlantic Canadians more or less likely to access MAID for mental illness? If so, what are they?

Part III: Moving forward

[*We have discussed at length how things are currently, and how things might be when MAID-MI is legalized, and we have covered some tough topics. I want to end the interview by imagining that a better world is possible, and asking you to envision what that looks like*]

What recommendations would you provide for policy-makers to create a MAID policy that prioritized the needs of 2S/LGBTQ+ people and those in your other communities?

- This could include eligibility criteria for MAID, accessibility, implementation, or things surrounding/on the periphery of MAID-specific policy (such as accessibility of mental health supports, etc.)

What are current sources of strength/support for you and your communities, and how do those currently available to you compare with those that would be available in your ideal world? How can these sources of strength/support be created, reinforced, or supported?

What would "thriving" look like for you and your communities? Alternatively, what would justice look like for you and your communities?

Is there anything else you'd like to share? This can be about MAID for mental illness, about your identity, your communities, your experiences in Atlantic Canada, or anything else you feel is important.

Appendix F – MAID fact sheet

Who can get MAID?

- In Canada, medical assistance in dying (MAID) is currently available to people with terminal (as of 2016) OR non-terminal (as of 2021) conditions.
- Canada plans to make MAID available to people whose **only** medical condition is a mental illness.
    - This expansion was delayed for a year in February 2023, and was set to occur on March 17, 2024, but a further delay was announced on January 29, 2024.
    - On February 29, 2024, Bill C-62 was passed, officially delaying the legalization of MAID for mental illness until March 2027.
- You must meet all of the following criteria:
    - Be eligible for health services funded by a province or territory, or the federal government
    - Be at least 18 years old and mentally competent (capable of making health care decisions for yourself)
    - Have a grievous and irremediable medical condition
    - Make a voluntary request for medical assistance in dying
    - Give informed consent to receive medical assistance in dying

What are the safeguards in place?

- For ALL cases of requests for MAID:
    - Two physicians/nurse practitioners must assess the request for MAID and agree that the requestor meets all of the eligibility criteria.
        - These physicians/nurse practitioners must be independent from one another and must not be in a position where they would benefit from the requestor's death.
    - The requestor must make a written request for MAID, signed by an independent witness.
    - The requestor must be aware that they can withdraw their request at any time.
    - The requestor must provide final consent before receiving MAID.
- For requests of MAID where natural death is not reasonably foreseeable (i.e., non-terminal/non-fatal conditions) – track 2 MAID.
    - One of the two assessors must have expertise in the medical condition for which the requestor is seeking MAID. If this is not the case, the assessors must consult a physician/nurse practitioner who does have that expertise.
    - The assessors must inform the requestor of all available means to relieve their suffering and, when applicable, must offer consultations with professionals who provide those services.
    - The assessors and requestor must discuss all reasonable and available means to relieve suffering, and must all agree that the requestor has seriously considered these options.

    - There must be 90 days between the day that the first assessment is conducted and the day that MAID is provided.
- There will be no specific safeguards in place for cases of MAID for mental illness; they will be the same safeguards that apply to any case of track 2 MAID.
- Provinces are able to set additional safeguards, rules, or laws that relate to MAID.

Additional notable facts:

- If a person is deemed ineligible for MAID by a physician or nurse practitioner, the person can seek another assessment from a different assessor.
- There is continuing conversation among physicians, nurse practitioners, psychologists, and other healthcare professionals as to whether or not a request for MAID in the case of mental illness can be distinguished from suicidality.

Additional resources:

https://www.canada.ca/en/health-canada/services/health-services-benefits/medical-assistance-dying.html

https://www.canada.ca/en/department-justice/news/2023/03/eligibility-for-medical-assistance-in-dying-for-persons-suffering-solely-from-mental-illness-extended-to-march-17-2024.html

https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/expert-panel-maid-mental-illness/final-report-expert-panel-maid-mental-illness.html