



Suicide Crisis Helpline  
Ligne d'aide en cas de  
crise de suicide

## Submission to the Special Joint Committee on Medical Assistance in Dying

April 27, 2026

Good evening, committee members. My name is Dr. Allison Crawford. I am a psychiatrist, Chief Medical Officer for 9-8-8: Suicide Crisis Helpline, and a Professor at the University of Toronto. I am also Principal Applicant on a CIHR-funded study examining MAID and suicide in the crisis line context.

I will be direct: I do not believe Canada should expand MAID to include those whose underlying condition is a mental disorder.

This is based on four core points: what we are seeing at 9-8-8; the absence of evidence that requests for MAID for mental disorder can be reliably distinguished from suicidal intent; shortcomings of recent clinical guidance; and public-health and media risks.

First, frontline signals from 9-8-8. Up to 7% of interactions on 9-8-8 refer to MAID. Critically, among those who referenced MAID, 74% endorsed thoughts of suicide in the past two days compared with 48% among other contacts. In short: interactions with our national suicide crisis line that reference MAID are associated with substantially higher suicidal ideation. This is not a theoretical concern; it is a real, measurable, elevated risk among people who mention MAID to Canada's suicide prevention service.

Second, we know that suicidal thoughts and behaviours are very common across psychiatric diagnoses, and are treatable.<sup>1</sup> Our systematic review of peer-reviewed literature found no credible evidence that suicidal intent can be reliably distinguished from an interest in MAID when the sole underlying condition is a mental disorder.<sup>2</sup> Both suicide and MAID represent an intention to die; both often



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stem from the same underlying drivers — intolerable suffering, hopelessness, perceived burdensomeness, and often social adversity. We also found no validated tools or assessment instruments that can reliably discriminate “suicidality” from a “reasoned wish to die” in the MAID context.

Third, recent guidance from the Canadian Psychiatric Association does not resolve these clinical or operational gaps.<sup>3</sup> The guidance is largely aspirational: it asks assessors to differentiate acute suicidal crisis from a well-considered wish to die, but offers no operational framework, no clear criteria, and no specification of structured tools. The guidance also fails to incorporate a standardized equity assessment to determine when social determinants and remediable needs are driving suffering. In practice, this leaves clinicians without the evidence-based procedures needed to safely assess risk or to embed suicide-prevention into MAID pathways.

Fourth, there are public-health risks in the way MAID and suicide are discussed publicly and in the media. Our recent research, currently submitted for peer review, highlights that the media often conflates MAID with suicide or fails to use established, responsible media guidance for reporting on suicide.<sup>4</sup> We lack guidance on safe communication about MAID and on preventing contagion effects, which should be a concern in making MAID for mental disorder an option. As MAID becomes more visible, the absence of responsible public messaging increases the risk of that people will see MAID as a means of alleviating their mental suffering and this will undermine suicide prevention efforts.

Additionally, we must also acknowledge current system realities: mental-health services across Canada remain under-resourced, with long waits and inequitable access.<sup>5,6</sup> These circumstances can produce or exacerbate the suffering that may drive MAID requests *and* suicidal thoughts and behaviours.



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My recommendation is straightforward: do not expand MAID to cases where the sole underlying condition is a mental disorder. This recommendation aligns with the position of the International Association for Suicide Prevention, that the overlap between MAID requests and suicide makes distinguishing between them impossible, and that MAID for mental illness will undermine suicide prevention by positioning MAID as a viable alternative to treatment.

Suicide is preventable. The vast majority of people who contemplate or attempt suicide do not go on to die by suicide.<sup>7</sup> Public health approaches to suicide prevention have been a priority in Canada which is one of the reasons the establishment of 988 received unanimous support in the House of commons. Given the significant overlap between suicidal thoughts and behaviours and MAID, we will best serve those who are suffering with enhanced suicide prevention efforts. And, by shifting our focus to medical assistance in living. This is what Canadians deserve.

Thank you. I am happy to answer questions and to share the data and documents cited in my written submission.

#### Citations

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4. Crawford A, Serota K, Sobers M, Sinyor M, Gnat L, Toala E, Schneider R, Grunau M, Niederkrotenthaler T. “Reporting on “the suicide bill”: A media analysis of the relationship between suicide and MAID in Canada (2014-2025).” (submitted for review)
5. Wait Times for Community Mental Health Counselling [Internet]. Canadian Institute for Health Information; 2025 Oct [cited 2026 Apr 20]. Available from: <https://www.cihi.ca/en/indicators/wait-times-for-community-mental-health-counselling>
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