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Mental illness segregation and truncated autonomy within medical assistance in dying legislative frameworks in Colombia and Canada

Hamer Bastidas-Bilbao ,[1] Ximena Palacios-Espinosa,[2] Donna E Stewart,[3,4] Vicky Stergiopoulos[4,5]

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For numbered affiliations see end of article.

Correspondence to
Hamer Bastidas-Bilbao;
hamer.bastidas-bilbao@uhn.ca

Colombia and Canada are the only jurisdictions in the Americas that have adopted countrywide frameworks on medical assistance in dying (MAiD), also known as physician-assisted death, for terminal and non-terminal illnesses. Both countries have excluded mental illness as a sole condition from eligibility to date. In this forum article, we adopt the notion of truncated autonomy to critically analyse how individuals with mental illness have been impacted by specific instances of legislative inaction and misdirected action, identified throughout the development of the current legislative frameworks on MAiD in each country. To develop our argument, we will introduce an overview of definitions and relevant debates on MAiD. We then present snapshots of Colombia's and Canada's healthcare systems along with some pressing public mental health concerns in each country. Finally, we will examine the development history of the legislative frameworks on MAiD adopted by each jurisdiction, highlighting instances of legislative inaction and misdirected actions that have contributed to the current paradoxical portrayal of mental illness as a condition that cannot be treated as equal to other illnesses considered non-mental. We conclude by arguing that an artificial divide between illnesses places individuals with mental illness into a situation of legal uncertainty that truncates their autonomy by undermining their equitable access to healthcare and protection of their human rights. We also reflect on the relevance of systematic participatory practices, including systematic exploration and incorporation of the views and care preferences of people living with mental illness, for the development and refinement of legislative and regulatory frameworks on MAiD in jurisdictions that might actively discuss or consider its adoption in the future.

DEFINITION AND CURRENT DEBATES

The notion of 'good death' has been a subject of debate and controversy. In antiquity, Plato's writings described the idea that the life of a patient unable to live normally should not be medically prolonged, but he also posited that a physician who administers a drug to terminate life should be punished by death.[1] Perspectives grounded on philosophy, science, religion, and bioethics, among others, on what constitutes a good death, and the role of health providers in it, have been described throughout history. At present, MAiD, as an approach to a good death, remains a controversial topic whose overall acceptability can vary ostensibly among patients, families, health professionals and other stakeholders.

MAiD involves medically assisting a patient with capacity who voluntarily seeks and consents to end their life, due to the presence of an incurable illness leading to irreversible decline in capability and intolerable suffering that cannot be alleviated with currently available treatments or other forms of support.[2] MAiD definitions can vary among jurisdictions but concur in identifying the presence of a grievous and incurable illness, intense suffering, uncoerced and informed individual consent and the assistance of a physician. In jurisdictions where MAiD is only available for terminal illnesses, a reasonably foreseeable natural death is a prerequisite. MAiD can take place in hospitals, other facilities, the patient's home or other places. In all cases, MAiD is administered after strict medical evaluation.

Only a few countries and jurisdictions have legalised or decriminalised MAiD. Germany, Italy, New Zealand and a number of states in Australia and the United States allow MAiD in cases of terminal illnesses.[3] Additionally, Austria, Belgium, Canada, Colombia, Luxembourg, the Netherlands, Spain and Switzerland allow MAiD eligibility in cases of both terminal and non-terminal conditions.[3] Among this latter group, MAiD eligibility is also extended to persons living with mental illness as the sole underlying medical condition (MI-SUMC), except in Colombia and Canada.[3] In recent years, Canada has considered a potential expansion of MAiD eligibility to cases of MI-SUMC.[2]

Given the multifaceted nature of MAiD, contentiousness heightens when the eligibility of patients whose death is not reasonably foreseeable is considered: this includes people living with a non-terminal non-mental illness as well as people living primarily with mental illness. Recent studies on the use of MAiD in cases of non-terminal illnesses, including mental illness, highlighted patient autonomy and the individual experience of intolerable suffering as key arguments in support of MAiD access.[4–6] Conversely, arguments against the potential eligibility of non-terminal illnesses, including mental illness, have emphasised the role of negative social determinants of health, including limited access to high-quality healthcare, as a source of contextual coercion and hopelessness.[4–8] Other relevant arguments have emphasised how mental illness can negatively impact the patient's capacity,[4–8] along with the challenges inherent to distinguishing the patient's desire to hasten their own death from a symptom of illness (eg, psychosis, suicidal thinking, hopelessness, pessimism).[9] The irremediability of mental illness has also been questioned.[8] These factors highlight how individual autonomy is situated at the core of the MAiD debate and conceptualised in divergent perspectives: autonomy can be conceptualised as an individual disposition that could be potentially impaired by illness or potentially subjected to contextual coercion; autonomy can also be seen as a disposition that empowers individuals to find relief from suffering or to persevere in a journey against the adversity brought on by illness.

Paradoxically, individual autonomy does not fully materialise regardless of the potential inclusion or sustained exclusion of mental illness from MAiD eligibility. We argue that autonomy is truncated from the outset by legislative frameworks that, due to explicit inaction and misdirected actions, portray mental illness as a phenomenon that cannot be accepted as equal to other illnesses considered non-mental. Furthermore, current legislative frameworks perpetuate the stigma surrounding mental illness by legitimising a form of illness-based segregation that places individuals with mental illness in a situation of both inequitable access to healthcare and inequitable protection of their human rights. By analysing the development of the only countrywide MAiD frameworks in the Americas, adopted in Colombia and Canada, we embrace the notion of truncated autonomy to understand the paradox emerging from current laws and policies on MAiD and healthcare that prevent individuals with mental illness from fully exerting their autonomy to search for socially legitimate ways to relieve themselves from intolerable suffering.

Colombia and Canada—background by country and healthcare system snapshots

Colombia and Canada are countries located across the Americas. Colombia is a middle-income country, located in upper South America. Canada is a high-income country, located north of the United States. Despite somewhat similar population sizes, including a relatively similar number of Indigenous peoples, both countries have ostensibly different cultures, economies and healthcare systems. A brief comparison of demographic and healthcare system statistics is presented in table 1.

Colombia has some of the lowest Organisation for Economic Co-Operation and Development (OECD) indicators regarding health system expenditures per capita, employment in the health sector, practising nurses per 1000 population and nursing graduates,[10] and its healthcare system operates mostly as a private profit-oriented managed healthcare system funded by mandatory contributions of formally employed citizens, employers and the government.[11] In contrast, Canada is above the OECD average in all broad categories of population health and health system performance, despite lower-than-average metrics regarding the numbers of practising doctors and hospital beds per 1000 population.[10] Health system expenditure, as a proportion of gross domestic product, and the number of nursing graduates are both above the OECD average.[10] The Canadian healthcare system is funded by federal, provincial and territorial taxes. Healthcare is universal and mostly administered and delivered by each province and territory.

Colombia—mental health

Mental health is a major public health concern that has been exacerbated by a history of armed conflict, and subsequent forced diaspora, which began in the 1960s with the formation of two major guerrillas, the National Liberation Army (in Spanish, ELN) and the Colombian Revolutionary Armed Forces (in Spanish, FARC). This conflict evolved over time to include other armed actors, including paramilitary forces.[12] Despite the 2016 accord with the FARC, along with other peace initiatives, peace still seems elusive, and organised violence and drug trafficking remain a threat to rural and urban communities across the country. The negative health impacts borne by the population are notorious. The prevalence of mental disorders among adults is estimated at 10% and rises to 15% among victims of armed conflict.[13] Among Indigenous people, 17.8% reported having been forcibly displaced due to armed conflict, and 16.2% reported excessive use of alcohol.[14] Suicide is also a significant concern in Indigenous communities; such is the case of the Emberá Dobidá people, where the estimated suicide

Table 1 Basic demographic and healthcare system statistics by country

	Colombia	Canada
Population in millions (latest census)	48.3 (2018)	36.9 (2021)
Indigenous population in millions (latest census)	1.9 (2018)	1.8 (2021)
Poverty	36.6%[30]*	7.4%[31 32]†
Extreme or deep poverty	13.8%[30]‡	3.6%[31 32]§
Gross national income per capita—World Bank (year of estimate)	US$6500 (2022)	US$53 310 (2022)
Quality of care—OECD indicators[10]	Higher than OECD average performance on 33% of indicators. Data missing for 30 out of 33 indicators.	Higher than OECD average performance on 63% of indicators. Data missing for 6 out of 33 indicators.
Access to care—OECD indicators[10]	Higher than OECD average performance on 50% of indicators. Data missing for 12 out of 18 indicators.	Higher than OECD average performance on 64% of indicators. Data missing for 7 out of 18 indicators.
Health system resources—OECD indicators[10]	Performance not higher than OECD average on any indicators. Data missing for 19 out of 32 indicators.	Higher than OECD average performance on 52% of indicators. Data missing for 5 out of 32 indicators.
Prevalence of mental disorders	9.9% in individuals 18+ years of age.[13] 15% among victims of armed conflict.[13]	18% in individuals 15+ years of age.[18]
Suicide mortality rate per 100 000 population (latest estimate)[16]	3.9 (2019)	11.8 (2019)

*In Colombia, the poverty line is estimated as a monthly income of approximately US$373 or less, for a 4-person household in 2022.
†In Canada, the poverty line varies between population centres. In 2021, it ranged from US$30 813 per year in small population centres in Québec, up to approximately US$40 344 per year in the Vancouver metropolitan area.
‡In Colombia, extreme poverty is estimated as a monthly income of approximately US$187 or less, for a 4-person household in 2022.
§In Canada, deep poverty represents income levels below 75% of the poverty line in the corresponding population centre.
OECD, Organisation for Economic Co-Operation and Development.

rate in 2015 was 247.9 per 100 000 population[15] in contrast with the country estimate of 3.9 per 100 000 population.[16]

Victims of the conflict—disproportionately comprised of the poorest individuals, and Indigenous people—and victims of other violent crimes, have a notably heightened risk of suffering from a mental disorder.[13] This risk is further exacerbated in unemployed or precariously employed individuals.[13] Moreover, there are major barriers to accessing healthcare related to individual attitudes towards mental health, stigma and discrimination, instrumental barriers (ie, untimely access, long-distance travel to healthcare facilities) and high religiosity that leads people to interpret signs of emotional or mental disturbances as conditions unrelated to health.[17] Consequently, evidence has shown that only about a third of people in need of mental health services request them and, among those who do request mental health services, less than 80% receive them.[17]

Canada—mental health

Mental health is also a major public health concern in Canada. In 2022, it was estimated that about 18% of Canadians 15+ years of age met diagnostic criteria for an anxiety, mood or substance use disorder in the previous 12 months, with the highest prevalence observed among young women.[18] Additionally, suicide is the second leading cause of death among individuals between 15 and 34 years of age.[19] Suicide affects men in larger proportions than women; rates of suicide are also higher among individuals experiencing material deprivation and social isolation.[19] Furthermore, suicide rates among First Nations, Inuit and Métis peoples are higher relative to their non-Indigenous counterparts.[19] Inuit communities are the most affected by suicide, with a rate 6.5 times higher than non-Indigenous people.[19] Despite Canada's universal healthcare, over a third of Canadians have reported partially or fully unmet mental healthcare needs, especially for counselling.[18]

The evolution of Colombian and Canadian MAiD legislative frameworks

MAiD entered the legal landscape after successful constitutional challenges in 1997 in Colombia and 2015 in Canada. The case of Rodriguez v. British Columbia, although unsuccessful, was also an important precedent in Canada in 1993. An overview of relevant milestones in the development of each country's MAiD legislative framework is presented in table 2.

In Colombia, the Constitutional Court issued the first ruling on MAiD in 1997, when euthanasia was decriminalised for patients with terminal illnesses.[20] However, a 2014 ruling highlighted that, despite the 1997 court decision, patients were unable to access euthanasia due to the absence of implementation, monitoring and reporting regulations and guidelines, which were progressively developed between 2015 and 2021, including regulation decreed in 2018 on the eligibility of minors 12+ years old, and guidance for exceptional circumstances involving minors 6–12 years old.[20] In 2021, another constitutional challenge resulted in sentence C-233/21,[21]

Table 2 Overview of relevant milestones in the development of MAiD legislative frameworks by country and current status of MAiD MI-SUMC

	Colombia	Canada
First legal precedent allowing MAiD	1997: Sentence C-239/97.[21] The Constitutional Court decriminalised euthanasia for terminal illnesses. This ruling was issued in response to a constitutional challenge of the Criminal Code. No legislation was passed by Congress.	2015: Carter v. Canada. The Supreme Court of Canada struck down sections of the Criminal Code deemed in violation of the Charter of Rights and Freedoms. MAiD was allowed for terminal illnesses. Legislation was adopted by Québec in 2015, and countrywide in 2016 through Bill C-14.[2]
Legal precedent on MAiD for non-terminal illnesses	2021: Sentence C-233/21.[21] The Constitutional Court extended euthanasia eligibility to non-terminal illnesses. This ruling was issued in response to a constitutional challenge of the Criminal Code. No legislation was passed by Congress.	2019: Truchon c. Procureur general du Canada. The Superior Court of Québec ruled that eligibility based on a reasonably foreseeable natural death was in violation of the Charter of Rights and Freedoms. Subsequent legislation was adopted countrywide in 2021 through Bill C-7.[2]
Most recent legal precedent on MAiD	2022: Sentence C-164/22.[21] The Constitutional Court decriminalised assisted suicide and defined it as a form of MAiD. This ruling was issued in response to a constitutional challenge of the Criminal Code. No legislation was passed by Congress.	2024: Bill C-62.[22] The Criminal Code clause excluding mental illness from MAiD eligibility will no longer be repealed on March 17, 2024, but on March 17, 2027. A parliamentary review must take place within 2 years from royal assent.
Status of MAiD MI-SUMC	Sentence C-233/21[21] of 2021, Section 433: 'It does not pertain to the Constitutional Court to determine specific circumstances wherein the suffering derived from mental conditions could justify accessing a service of dignified death. Such possibility pertains to a specific case-based analysis conducted, in principle, by the healthcare system and, only eventually, by a judge of constitutional injunctions.'*	Criminal Code, Section 241.2 (2.1): 'For the purposes of paragraph (2)(a), a mental illness is not considered to be an illness, disease or disability.'

*Translation by the authors.
MAiD, medical assistance in dying; MI-SUMC, mental illness as the sole underlying medical condition.

extending euthanasia eligibility to people suffering from non-terminal illnesses. This ruling introduced a caveat, whereby the court established that it was not competent to determine the situations in which mental illness would justify granting access to euthanasia, as such determination can only be made by the healthcare system or, eventually, by a judge specialising in constitutional injunctions (known in Colombia as *juez de tutela*). In 2022, the Constitutional Court decriminalised assisted suicide and defined it as a form of MAiD.[20] The first cases of euthanasia for non-terminal illnesses occurred in early 2022, involving two patients with chronic obstructive pulmonary disease and amyotrophic lateral sclerosis, respectively, whose cases were widely reported in the local media. No cases of euthanasia for MI-SUMC have been reported. Despite years-long delays in implementation, Colombia's current MAiD legal framework is considered one of the most advanced in the world and the only one adopted so far among Latin American countries.

In Canada, MAiD became legally permissible in 2016 for Canadians suffering from medical conditions deemed irremediable, grievous, and leading to a reasonably foreseeable natural death,[2] and eligible for publicly funded healthcare. In 2017, the eligibility criterion of a foreseeable natural death was successfully challenged before the Superior Court of Québec.[2] In 2021, Bill C-7[22 23] received royal assent and established two separate MAiD tracks for terminal and non-terminal illnesses. However, MI-SUMC was excluded from MAiD eligibility.[2] Such exclusion was initially scheduled to expire in March 2023, only to be later extended through to March 2024 on the introduction of Bill C-39.[22] In February 2024, the federal government introduced Bill C-62[22] to further extend the exclusion clause for an additional 3 years, with a proviso that a parliamentary review will again take place within this period, hence opening the door to further changes to the MAiD MI-SUMC implementation timeline. Bill C-62[22] received royal assent on 29 February 2024.

Mental illness segregation and truncated autonomy

Personal autonomy can be conceptualised in different ways as it is influenced by elements of culture and social order,[24] including economic and political systems.[25] In neoliberal economic and political systems, such as Colombia and Canada, autonomy is construed as individual self-reliance, self-interest, competition, calculation and accountability.[26] The development history of Colombia's and Canada's current legislative frameworks on MAiD, along with each country's stance on the application of MAiD to cases of MI-SUMC, illustrates how both countries, despite their historical and socioeconomic differences, curtail the autonomy otherwise expected

of individuals by legitimising an artificial segregation between mental illness and other illnesses considered non-mental. Such an artificial segregation emerges due to multiple and identifiable instances of legislative inaction and misdirected actions that prevent people living with mental illness from having access to equitable healthcare, social welfare supports consistent with the biopsychosocial nature of mental illness, and even from accessing MAiD as a last resort amid individual experiences of intolerable suffering that cannot be otherwise alleviated.

First, the Colombian MAiD framework is the result of multiple constitutional challenges that have resulted in the decriminalisation of MAiD. However, an evident instance of inaction can be identified in the lack of legislation by Congress on the issue of MAiD for terminal and non-terminal illnesses. Ever since its first 1997 ruling, the Constitutional Court has exhorted Congress to legislate on MAiD but, more than two decades later, no legislation on the matter has been passed; in contrast, in 2014, Congress introduced and approved specific legislation on palliative care, Law 1733,[27] and defined it as a life-affirming medical practice. Another instance of inaction can be identified in the refusal of the Constitutional Court to issue a ruling on the applicability of MAiD to cases of MI-SUMC. Across the Americas, in Canada, another instance of inaction is evidenced in the lack of modernisation of the Canada Health Act, adopted in 1985, which continues to exclude community-based services provided by non-physicians from coverage, resulting in access barriers to mental healthcare services.

On the other hand, there are a number of identifiable misdirected actions, both in Colombian and Canadian MAiD frameworks, which appear to have the purpose of communicating caution and carefulness amid a polarising debate but result, paradoxically, in a stigmatising portrayal of mental illness to the general public. In Colombia, although the Constitutional Court did not rule out the use of MAiD in cases of mental illness, it instead deferred all responsibility for making such determination to the healthcare system or, in some instances, to judges specialising in constitutional injunctions, which further misrepresents mental illness as a condition that does not fully belong within the realm of healthcare knowledge. In Canada, multiple instances of misdirected action can be identified as well. Specifically, in the preamble to Bill C-7, MAiD MI-SUMC is described as having 'inherent risks and complexity' (p2) that justify additional consultations and deliberation. Furthermore, it amended the provisions of the Criminal Code on MAiD by introducing Section 241.2 (2.1) stating that 'a mental illness is not considered to be an illness, disease or disability'. Finally, Bill C-7's sunset clause excluding mental illness from MAiD eligibility for 2 years, and its subsequent 1-year and 3-year extensions, adopted by the Federal Government in 2023 and 2024, exemplify additional misdirected actions.

The implications of the instances of inaction and misdirected action described above are multiple and result in an explicit truncation of the autonomy otherwise embraced by neoliberal political and economic systems. In both countries, Colombia and Canada, current legislative frameworks relegate individuals living with mental illness to a place of legal uncertainty where mental illness is portrayed to the public as a condition whose nature is distinct from that of other illnesses. Despite scientific evidence of the role of biological, psychological and social factors in illness predisposition, precipitation and perpetuation, the current legislative MAiD frameworks adopted by both countries render the equitable treatment of mental illness unjustifiable under the law. This occurs in open contradiction to each country's mental health promotion and antistigma policies and mandates. Furthermore, in both jurisdictions, the continued avoidance of setting a precedent regarding the applicability of MAiD to cases of MI-SUMC operates as a form of social indecision. By resorting to deferring or delaying decision-making, social transitions are barred from occurring; this helps the political and economic systems avoid an introduction of structural changes in response to the need for societal change, including equitable investments in mental healthcare and social welfare. Political election considerations, along with misinformation, should also be acknowledged as underlying factors permeating social indecision; these factors coexist with opposition to MAiD from some informed stakeholders.

A tension between social indecision and due diligence hence becomes evident. The necessary debates on the adequacy of practice guidelines and related safeguards for MAiD MI-SUMC are an example of due diligence. However, the pursuit of widespread consensus among medical, legal and other expert stakeholders, without a concurrent transformation of the healthcare and social welfare systems carries with it a risk of subjecting individuals living with mental illness to an even more burdensome external control of their healthcare decisions, unequal standards for accessing healthcare and further truncation of their autonomy. Consequently, individuals with mental illness now find themselves falling into a grey area rooted in an artificial segregation between illnesses that excludes them not only from a healthcare system that should otherwise provide equal care but also from a legal system that should otherwise guarantee equal rights to all individuals and ensure their access to the protections enshrined in Law 1752[27] in Colombia, or the Canadian Charter of Rights and Freedoms, against discrimination based on any form of physical or mental disability.

No longer considered self-reliant, self-interested and fully accountable, individuals with mental illness are now redefined as dependent and unaccountable subjects, whose need for relief from suffering can be selflessly postponed given its lack of legitimacy within the current legislative frameworks. Paradoxically, although the need for equitable access to life-sustaining essentials—such as a safe environment, housing, basic holistic healthcare and income support—is amply discussed as a key argument against the adoption of MAiD for non-terminal illnesses, including mental illness, the legal uncertainty imposed

on these individuals, on the basis of an illness artificially segregated from others, perpetuates the status quo where comprehensive social welfare remains antithetical to the type of autonomy sanctioned by neoliberal economic and political systems. Colombia's and Canada's MAiD frameworks have managed to avoid a commitment to establish holistic biopsychosocial care pathways for individuals with mental illness, leaving their autonomy truncated, and with some of them at risk of finding themselves enduring a lifetime of intolerable suffering, often shortened by a lack of holistic treatment or social welfare, or opting for an undignified death by suicide, regardless of the potential inclusion or sustained exclusion of mental illness from MAiD eligibility. Moving beyond a dichotomous approach to the debate on MAiD MI-SUMC could help appraise the complexity of this intervention, the pressing need for structural social and healthcare changes in both countries, and the unintended consequences of pursuing an ideal of widespread consensus in matters for which consensus might not be attainable.

Recommendations and conclusions

By examining and analysing the only countrywide legislative frameworks on MAiD in the Americas, we identified instances of inaction and misdirected action that have legitimised a conceptual and practical segregation between mental illness and other illnesses considered non-mental, resulting in a truncation of the very autonomy sanctioned by the neoliberal political and economic systems of Colombia and Canada. While we acknowledge the challenges inherent to developing legislation and regulation on MAiD in contexts with unique social and historical characteristics, we are of the opinion that MAiD MI-SUMC regulation—including practice guidelines and safeguards—can benefit from a development process that is closely articulated with healthcare systems in each jurisdiction, with special emphasis on devising systematic participation mechanisms for patients, healthcare providers and other relevant stakeholders, throughout all stages of their development, including evaluation. Notably, approaches to the development and evaluation of complex healthcare interventions have been discussed in the literature, including the application of a complexity-informed approach to programme evaluation of MAiD MI-SUMC[28]; these approaches are characterised by a high degree of participation, particularly from individuals identified as the main users of the envisioned healthcare intervention. This can constitute a first step towards the adoption of innovative practices in participatory regulatory development in Colombia, Canada, and other jurisdictions that might actively discuss or consider MAiD MI-SUMC in the future.

Our own previous research, reported by authors VS, HB and DES, has explored the perspectives of people with mental illness, and family members, on care considerations for the implementation of MAiD MI-SUMC in Canada, including aspects related to the potential role of interdisciplinary healthcare teams and professionals such as psychiatrists and others specialising in mental health; this evidence exemplifies how these key stakeholders can play an active role in the development of knowledge that could be used as input to inform further regulation and, potentially, legislation on the matter.[29] In Colombia, similar studies are yet to be conducted. This is relevant as the country's current regulation requires MAiD requests to be overseen and resolved by an interdisciplinary scientific committee (in Spanish, *comité científico interdisciplinario para el derecho a morir con dignidad*), which includes a physician (other than the treating physician) with expertise in the medical condition leading to the MAiD request, a psychiatrist or clinical psychologist responsible for assessing the patient's capacity, and a lawyer. However, this configuration was established 6 years before the 2021 constitutional challenge that resulted in the inclusion of non-terminal illnesses as conditions eligible for MAiD, making it necessary to develop updated practice guidelines and safeguards to respond to the needs of patients with non-terminal illnesses, without implicit or explicit exclusion of those with mental illness. This presents an opportunity window to generate participatory knowledge that could inform regulatory developments in the local context. An opportunity window is also present in Canada, given the recently extended exclusion of mental illness from MAiD eligibility, and accompanying discussions on healthcare system readiness and rights equity. Both countries now face the task of responding to the challenges associated with the conceptual and practical segregation between illnesses still ingrained in their respective MAiD frameworks.

Finally, critical analyses of legislation and policy developments on complex healthcare interventions, like the one presented herein, are useful to foster awareness of the unintended impacts associated with laws and policies—such as those on MAiD for non-terminal illnesses in Colombia and Canada—emerging within specific economic and political systems, and their underlying values. Re-examining the assumptions at the core of the legislative frameworks' portrayal of mental illness, its sufferers, and their needs, can help elucidate ways in which the autonomy of people living with mental illness is challenged and truncated, either in pursuit of holistic healthcare, including social welfare, or in pursuit of the end of life.

Author affiliations
[1]Toronto General Hospital and Centre for Mental Health, University Health Network, Toronto, Ontario, Canada
[2]School of Medicine and Health Sciences, Universidad del Rosario, Bogotá, Colombia
[3]Toronto General Hospital Research Institute and Centre for Mental Health, University Health Network, Toronto, Ontario, Canada
[4]Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada
[5]Centre for Addiction and Mental Health, Toronto, Ontario, Canada

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ORCID iD

Hamer Bastidas-Bilbao http://orcid.org/0000-0002-1103-6530

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Hamer Bastidas-Bilbao earned a bachelor's in psychology (2009), a master's in clinical and health psychology (2011), and a PhD (2016) in education from Universidad de los Andes, Bogotá, Colombia. In 2022, Dr Bastidas-Bilbao joined the Centre for Addiction and Mental Health (CAMH), Toronto, Ontario, Canada, as a post-doctoral research fellow with the Centre for Complex Interventions. Since 2023, he has been affiliated with University Health Network (UHN), Toronto, Ontario, Canada, and has been appointed as a research associate with the Toronto General Hospital and the Centre for Mental Health. He has previously worked on qualitative research exploring the views of people living with mental illness, together with family members' views, on the introduction and implementation of medical assistance in dying (MAiD) for mental illness as the sole underlying medical condition (MI-SUMC) in Canada. In addition to qualitative research on the experience of living with mental illness, his current main interests include complexity-informed programme evaluation of mental health services, as well as health professions education topics such as curriculum development and evaluation of research training programmes for mental health professionals.