

An International Comparison of Assisted Dying Regimes

Part 1—Eligibility Criteria

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Introduction

Euthanasia and assisted suicide were legalized in Canada in 2016 under the term “medical assistance in dying” (MAiD), and the legislation was expanded in 2021. Canada’s program has drawn international attention and concern, particularly due to its high uptake: 1 in 20 deaths as of 2024.¹ To better understand Canada’s MAiD program and possible ways to strengthen safeguards and limits, this brief is the first in a series that compares the parameters of MAiD in Canada with those of other countries in which some form of assisted dying is legal.

This first brief focuses on eligibility criteria: who can receive an assisted death, and for what reasons. In this brief we examine:

- Age criteria
- Suffering criteria
 - terminal prognosis
 - non-terminal suffering
 - psychiatric suffering as a sole underlying condition

1 In 2024, 5.1% of total deaths in Canada were MAiD deaths, as per Health Canada, *Sixth Annual Report*, 11. For examples of international media coverage, see: Yousif, “Assisted Dying,” *BBC*; “Canada’s Rate,” *The Guardian*; Moniuszko, “Medically-Assisted Dying in Canada,” *CBS News*. Complete citations are provided for all sources at the end of this report.

This comparison is presented through a series of tables, accompanied by discussion. We find that Canada’s program is much more permissive than those of Australia, New Zealand, and the United States. Eligibility criteria in Canada are similar to that of Spain and the Benelux countries (Belgium, Netherlands, and Luxembourg). Canada’s criteria relating to suffering is, however, more subjective than in Belgium or the Netherlands: in those countries, a physician’s agreement on a lack of reasonable alternatives is required.

Official governmental sources, including government websites, annual reports, legislation, and court cases were used for determining the legal parameters of assisted dying in a given country. Secondary sources, such as scholarly articles, were used to confirm this determination. Where official documents were not available in either English or French, translations were used and additional secondary sources were examined.² This process was more difficult in the cases of Uruguay, where assisted dying has only become available recently, and relevant peer-reviewed sources published in English were not found.

This brief relies on the legislation and policies as written, which does not tell us how the criteria and safeguards are functioning in practice. When possible, we refer to academic studies that provide such assessments.

Two Modes of Assisted Dying

The term “medical assistance in dying” (MAiD) in Canada refers to: (1) euthanasia or clinician-administered assisted death, and (2) assisted suicide or self-administered assisted death. The language used to refer to either or both practices varies by jurisdiction, as summarized in table 1. The international jurisdictions that are compared in this research brief permit one or both practices, and use a variety of terms (table 1). Australian states, for instance, allow both euthanasia and assisted suicide and refer to both as “voluntary assisted dying.” Some US states use the term “medical aid in dying” or “MAiD” but permit only assisted suicide, not euthanasia.

In this paper, we use “assisted dying” to refer to the legal availability of either or both practices in a given jurisdiction. When differentiation is needed, we use “euthanasia” for clinician-administered death and “assisted suicide” for self-administered death. We use “MAiD” when referring to the Canadian situation specifically.

Euthanasia usually occurs through clinicians administering lethal drugs intravenously, whereas assisted suicide is generally provided through clinicians prescribing or providing lethal drugs that patients self-ingest orally.³ In US states that allow assisted suicide, physicians prescribe the lethal medication for patients to take orally at a later point, but are not often present at the time of death.⁴ Typically in these US states, approximately one-third of those who are prescribed the lethal drug do not fill the prescription, or fill it but do not use it, for such reasons as a change

2 Where translations were not available, Google Translate was used.

3 For a review of the drugs used, see Worthington et al., “Efficacy and Safety of Drugs Used.”

4 In 2024 in Oregon, for instance, a majority of patients using prescribed lethal drugs did not have either the prescribing physician or another health care provider present at their deaths. Oregon Health Authority, *2024 Oregon Death with Dignity Act Data Summary*, 10.

of mind, incapacity, or occurrence of a natural death.⁵ By contrast, in jurisdictions such as Canada that allow both assisted suicide and euthanasia, clinician supervision is usually required for assisted suicide, and clinicians can “complete” the death intravenously (i.e., euthanize) if the assisted suicide fails or does not result in death in a certain amount of time.⁶

Although some jurisdictions allow both euthanasia and assisted suicide, in most places euthanasia accounts for the vast majority of assisted deaths. In Canada, fewer than five of the 15,343 MAiD deaths in 2023 (0.03 percent) were cases of assisted suicide. In 2024, all cases were euthanasia.⁷ Similarly, in the Netherlands in 2024, 1.88 percent of assisted deaths were assisted suicide, and 0.18 percent were a combination of assisted suicide and euthanasia, with clinicians “completing” the death when the patient did not die within the time frame agreed upon.⁸

In Australia, however, the proportions are not quite as stark. Although Australian legislation at the state level allows both euthanasia and assisted suicide, the proportion of cases that are assisted suicide is much higher than in Canada or the Netherlands. For instance, the state of Queensland reported that in 2024-25, 27 percent of cases were assisted suicide and 73 percent were euthanasia. The proportion has decreased over time in Queensland, however. In 2023-24 the proportions were 33 percent assisted suicide / 67 percent euthanasia, and in 2022-23 the proportions were 43 percent assisted suicide / 57 percent euthanasia.⁹

The Australian state of Victoria has an even higher preponderance of assisted suicide over euthanasia, with about 82.5% of cases between 2019 and 2024 being assisted suicide.¹⁰ In this jurisdiction, assisted suicide is set as “the default method and practitioner-administration is permitted only if the patient is physically unable to self administer or ingest the VAD [voluntary assisted dying] substance.” Further, it is “understood that many patients would opt for practitioner-administration if this option were available.”¹¹ The proportion of cases that are assisted suicide has decreased in Victoria over the years, and the proportion that are euthanasia has increased.

5 Pullman, “Slowing the Slide,” 68.

6 Worthington et al., “Efficacy and Safety of Drugs Used.” For Canada, see guidance provided in Canadian Association of MAiD Assessors and Providers, “Intravenous MAiD Medication Protocols in Canada”; Canadian Association of MAiD Assessors and Providers, “The Oral MAiD Option in Canada Part 1”; Canadian Association of MAiD Assessors and Providers, “The Oral MAiD Option in Canada Part 2.”

7 Health Canada, *Fifth Annual Report*, 17. Health Canada, *Sixth Annual Report*, 12. Citing privacy reasons, Health Canada does not provide an exact number of assisted suicides in its annual reports. The *Sixth Annual Report* is the first where zero self-administered cases were reported.

8 Regional Euthanasia Review Committees, Netherlands, *Annual Report 2024 (Eng. Trans.)*, 16.

9 Queensland Voluntary Assisted Dying Board, *Queensland Voluntary Assisted Dying Review Board Annual Report 2024–2025*, 17; *Annual Report 2023–2024*, 18; *Annual Report 2022–2023*, 15.

10 Victoria State Government, *Voluntary Assisted Dying Review Board Annual Report, July 2024 to June 2025*, 39. Percentage calculated based on data from Table 11.

11 Victoria State Government, *Review of the Operation of Victoria’s Voluntary Assisted Dying Act 2017*, 93.

Jurisdictions for Comparison

For the purposes of this brief, jurisdictions in which assisted dying has been legalized as of January 1, 2026 are included (table 1).

Although most of the jurisdictions are reported at a national level, reporting is provided at the sub-national level for countries whose constitutional structure permits sub-national jurisdictions to make their own laws regarding assisted dying (Australia and the United States). The Canadian province of Quebec, although governed by criminal law at the federal level, differs from the situation in other provinces, which will be mentioned when relevant. The province of Alberta, just prior to the publication of this brief, passed legislation which, when in effect, will create additional limits on eligibility and increase some safeguards. These will be discussed as relevant.

Table 2 presents jurisdictions that are excluded from the comparison. In most cases, assisted dying is decriminalized or legally tolerated to some extent in these jurisdictions, but a legislative framework that regulates the practice is lacking.

Table 1. Legalization and Terminology of Assisted Suicide and/or Euthanasia in Jurisdictions under Comparison

Jurisdiction	Sub-jurisdiction	Permitted: Euthanasia, assisted suicide, or both?	Government terminology	Date of legal availability
Austria		Assisted suicide	Assisted suicide	2022
Australia	Australian Capital Territory	Both	Voluntary assisted dying, differentiated as Self-administration (assisted suicide) and Practitioner administration (euthanasia), or similar wording, depending on the state	2025
	New South Wales			2023
	Queensland			2023
	South Australia			2023
	Tasmania			2022
	Victoria			2019
	Western Australia			2021
Belgium		Euthanasia	Euthanasia	2002
Canada ¹		Both	Medical assistance in dying, differentiated as Clinician-administered (euthanasia) or Self-administered (assisted suicide)	2016
Luxembourg		Both	Euthanasia, assisted suicide	2009

Table 1. (continued)

Jurisdiction	Sub-jurisdiction	Permitted: Euthanasia, assisted suicide, or both?	Government terminology	Date of legal availability
Netherlands		Both	Termination of life on request (euthanasia), Assisted suicide (assisted suicide). Euthanasia also used to refer to both.	2002 ²
New Zealand		Both	Assisted dying, differentiated as Self-administration (assisted suicide) or Administration by an attending medical practitioner or an attending nurse practitioner (euthanasia)	2021
Spain		Both	Euthanasia, Aid to die, differentiated as Direct administration or Self-administration	2021
Uruguay		Euthanasia	Euthanasia, Assistance in dying	2025
United States ³	California	Assisted suicide	Aid-in-dying	2016
	Colorado		Medical aid-in-dying, Aid-in-dying	2016
	District of Columbia		Death with Dignity	2017
	Delaware		Medical Aid in Dying	2026
	Hawaii		Medical Aid in Dying	2019
	Maine		Patient-directed care at the end of life, Death with dignity	2019
	New Jersey		Medical Aid in Dying	2019
	New Mexico		Medical Aid in Dying	2021
	Oregon		DWDA (Dying with Dignity Act) prescription recipients, DWDA deaths	1997
	Vermont		Medical Aid in Dying	2013
Washington	Death with Dignity end-of-life care	2009		

¹Quebec legalization of “*l’aide médicale à mourir*” (AMM) came into effect in December 2015, ahead of the federal legislative changes to the Canadian *Criminal Code*.

²The practice was legally tolerated starting in the mid-1980s, however. See Nicol, “Medical Assistance in Dying”, 11.

³In addition, Illinois and New York have passed legislation, which will come into effect later in 2026.

Sources: See reference list at end of report.

Table 2. Status of Assisted Suicide and/or Euthanasia in Jurisdictions Excluded from Comparison

Jurisdiction	Permitted: Euthanasia, assisted suicide, or both?	Legal status
Colombia	Both	Decriminalized via court decision in 2014. Ministry of Health regulations enacted in 2015. No comprehensive legislation.
Germany	Assisted suicide	Decriminalized via court decision in 2020. No current regulation or legislation.
Italy	Assisted suicide	Decriminalized via court decision in 2019. No current regulation or legislation.
Peru	Euthanasia	Illegal except under case-by-case exceptions ruled by the Constitutional Court.
Portugal	Both	Decriminalized by law in 2023 but has not yet been implemented due to political vetoes and court decisions.
Switzerland	Assisted suicide	Anchored in the criminal code since 1942 and provided by organizations (not the healthcare system) since 1985. A 2006 court decision made previous guidelines mandatory.
United States (Montana)	Assisted suicide	Montana court decision in 2009 ruled that the law would not prevent physician aid in dying and that existing law would shield physicians from prosecution for assisting patients who have a right to decide medical treatment at the end of life.

Sources: See reference list at end of report.

Eligibility Criteria

Eligibility for assisted dying typically involves criteria related to age, suffering, competency (capacity to make the decision), and residency. Age and suffering criteria are discussed in the present brief. Capacity and residency will be discussed in forthcoming briefs.

Age

In most countries of comparison, eligibility is restricted to adults. Only two of the other jurisdictions allow assisted dying for children: Belgium and the Netherlands. Canada has studied and considered the possibility of MAiD for “mature minors.”¹²

12 Special Joint Committee on Medical Assistance in Dying, *Medical Assistance in Dying in Canada*, 54-63; Council of Canadian Academies, *The State of Knowledge*.

Belgium does not provide an age limit but specifies that emancipated (legally independent) minors or any child with “capacity for discernment” can be found eligible.¹³ A 2015 constitutional court decision specifically excluded newborns and young children, given they lack this capacity.

Beyond the criteria applying to adults, children in Belgium must meet additional criteria, specifically:

- Child psychiatrist or psychologist must be consulted when the patient is an unemancipated minor, to understand the minor’s capacity for discernment.
- Physical suffering must be constant, intolerable, and not able to be relieved; assisted death on the basis of psychiatric suffering is excluded.
- The condition must be serious and incurable, and expected to lead to death in the short term.
- Parents/guardians must provide written consent.¹⁴

Table 3. Eligibility Criteria for Assisted Dying: Children

Jurisdiction	Children eligible?	Details
Austria	No	
Australia	No	
Belgium	Yes	No specified age, so long as the child has capacity for discernment
Canada	No	
Luxembourg	No	
Netherlands	Yes	Newborns: May be involuntarily euthanized Ages 1-12: May be involuntarily euthanized Ages 12+: May be euthanized upon the child's request
New Zealand	No	
Spain	No	
Uruguay	No	
United States	No	

Sources: See reference list at end of report.

13 Government of Belgium, *Loi relative à l'euthanasie*; Government of Belgium, “Euthanasie en Belgique.”

14 Government of Belgium, “Euthanasie d’une personne mineure.”

In the Netherlands, the age is set at 12 for a child to be eligible to request euthanasia, with varying additional criteria depending on age:

- Children aged 12 to 15 must have parent/guardian consent, and must have the capacity to understand what is best for themselves.
- Children aged 16 to 17 must have parent/guardian consultation (parental consent is not required).¹⁵

The Netherlands also allows involuntary euthanasia for terminally ill children aged 1 to 12, when decided upon by parents and the doctor.¹⁶ Severely ill newborn infants may be euthanized according to the Groningen Protocol.¹⁷

Suffering

Each jurisdiction has criteria relating to suffering, but the parameters differ in important ways. In each jurisdiction, eligibility involves the following:

- Some characterization of the nature of the condition or illness, usually with a requirement that it be irremediable, incurable, or irreversible. Some jurisdictions require that the condition or illness be terminal, often with a specific time frame specified.
- Some characterization that the suffering is severe and unbearable. The jurisdictions differ as to (1) whether the tolerability of the suffering is determined solely by the patient or together with the physician/assessor, and (2) whether reasonable alternatives to relieve suffering must be tried.

Prognosis

Perhaps the most significant difference in eligibility criteria across the jurisdictions is whether assisted dying is limited to those who are dying, or is available more generally to those who are suffering but not necessarily dying.

As indicated in table 4, US states, Australian states, and New Zealand limit eligibility to those who are terminally ill—with all but one of these specifying a prognosis of six to twelve months or less.¹⁸

15 Government of the Netherlands, “Is Euthanasia Legal in the Netherlands?”

16 Government of the Netherlands, “Termination of Life for Terminally Ill Children.”

17 Verhagen and Sauer, “The Groningen Protocol”; Government of the Netherlands, “Termination of Life Newborn Infants and Late-Term Abortion.”

18 The Australian Capital Territory, whose voluntary assisted dying program came into effect in November 2025, diverges from other Australian states by requiring that the patient’s condition(s) must be “expected to cause death,” without providing a timeframe for the expected death. Further, when defining an “advanced condition,” the law specifies that “an individual may be approaching the end of their life even if it is uncertain whether their relevant conditions will cause death within the next 12 months.” ACT Government, *Voluntary Assisted Dying Act 2024*, at § 11 (1)(b) and § 11(6).

Table 4. Eligibility Criteria for Assisted Dying: Terminal Diagnosis

Jurisdiction	Sub-jurisdiction	Terminal diagnosis required?	Prognosis time frame specified?
Australia	Australian Capital Territory	Yes	No
	New South Wales		6 months or less (12 months or less for neurodegenerative conditions)
	Queensland		12 months or less
	South Australia		6 months or less (12 months or less for neurodegenerative conditions)
	Tasmania		6 months or less (12 months or less for neurodegenerative conditions)
	Victoria		12 months or less
	Western Australia		6 months or less (12 months or less for neurodegenerative conditions)
Austria		No	No
Belgium		No (required for children only)	For children, death must be “in the near future” (no precise timeframe).
Canada		No ¹	No
Luxembourg		No	No
New Zealand		Yes	6 months or less
Netherlands		No	No
Spain		No	No
Uruguay		Unclear	No
United States	All relevant states	Yes	6 months or less

¹The province of Alberta has passed legislation which, when in effect, requires patients to have a 12 month prognosis to be eligible for MAiD. Sources: See reference list at end of report.

The Criterion of “Reasonably Foreseeable Natural Death” in Canada

Canadian legislation passed in 2016 required that the patient’s “natural death has become reasonably foreseeable,” but also that a prognosis of any particular length is not required.¹⁹ As discussed in a Justice Department document, this criterion would not limit MAiD to those with a “fatal disease,” as the “medical condition that is causing the intolerable suffering would not need to be the cause of the reasonably foreseeable death.”²⁰ Without a definition as to what

19 Bill C-14.

20 Government of Canada, *Legislative Background*, 10.

“reasonably foreseeable” meant in practice, a wide range of interpretations resulted, including ones in which the death may be even ten years away.²¹

After a Quebec court decision (*Truchon*), the Canadian Parliament passed new legislation in 2021 which, alongside other changes, created “Track 2” MAiD for those whose deaths were not reasonably foreseeable.²²

The lack of definition in Canada of “reasonably foreseeable death” continues to create significant challenges for differentiating between eligibility for Track 1 and Track 2, and consequently for knowing when certain safeguards, such as the ninety-day assessment period for Track 2, must apply.²³ Some researchers have expressed concerns about how MAiD assessors and providers may enable patients who more clearly qualify for Track 2 to qualify for Track 1 and thus access MAiD without the longer assessment period (with Track 1, there is no specific assessment period length, and assessment and receipt of MAiD can occur on the same day in some cases).²⁴ For example, the Canadian Association of MAiD Assessors and Providers provides the following guidance:

A person may meet the “reasonably foreseeable” criterion if they have demonstrated a clear and serious intent to take steps to make their natural death happen soon or to cause their death to be predictable. Examples might include stated declarations to refuse antibiotic treatment of current or future serious infection, to stop use of oxygen therapy, to refuse turning if they have quadriplegia, or to voluntarily cease eating and drinking.²⁵

In other words, if a patient normally considered to be Track 2 communicates that they intend to stop eating and drinking or refuse effective treatment, a provider could then potentially approve their MAiD request under Track 1, as the patient has now made their death “reasonably foreseeable.”

The province of Alberta recently passed a bill which, when it takes effect, removes Track 2 MAiD and adds a 12 month prognosis requirement.²⁶

Non-Terminal Suffering

Some jurisdictions do not restrict eligibility to those with terminal illnesses only. Canada is one of these. Table 5 provides a comparison of the criteria related to suffering in these jurisdictions (note: this is not a comparison of the nature of the medical conditions). The table indicates how criteria differ regarding:

- the possibility that the suffering will improve

21 McMorrow et al., “Interpreting Eligibility”; Stafinski et al, “Descriptions and Experiences,” 9.

22 For more information about the court cases, legislation, and ‘tracks’ of MAiD, see also Raikin, “From Exceptional to Routine” and Cardus, “Ethical Issues.”

23 Shannon, “We Should Not Lightly Assume,” 74–75.

24 Coelho, “Disability and MAiD,” 192–93.

25 Canadian Association of MAiD Assessors and Providers, “The Interpretation and Role of ‘Reasonably Foreseeable.’”

26 Government of Alberta, “Protecting vulnerable Albertans.”

- whether there are reasonable alternatives to relieve the suffering
- the role of physician discretion in determining whether reasonable alternatives exist

As table 5 shows, Canada’s law is significantly more permissive here. Researchers Scott and Scott have concluded that Canada’s “suffering eligibility criterion leaves the law open to unintended forms of interpretation, thus instituting perhaps the most unbounded and risk-prone form of assisted death in the world.”²⁷ In Canada it is the patient who decides that the suffering is intolerable, and the patient must only *consider* reasonable alternatives; there is no requirement for the patient to try treatment or alternatives.

Belgium and the Netherlands require physicians to assess the suffering. For a patient to become eligible, the physician must confirm it to be intolerable and must also confirm that alternatives are lacking.

The Netherlands also requires that “the physician must ensure that all potentially effective methods to alleviate suffering have been tried before having recourse to death as a solution,” whereas “in Canada, the physician does not have a duty to ensure that all viable treatments have been tried before having access to death as the solution.”²⁸ Scholars Mishara and Kerkhof report that “this obligation to treat is the main reason for refusing requests” in the Netherlands, and they note that “most people in the Netherlands who are refused on these grounds do not repeat their request for MAID after trying the recommended treatments . . . [which] avoids the expedited death of many people who requested euthanasia or assisted suicide.”²⁹ These scholars also contrast the “premise” of the laws in the two countries. The Netherlands’s law is premised on “a responsibility to alleviate suffering by allowing people to choose to die when life is unbearable, but there is also an obligation of the state to protect vulnerable individuals who may choose to die when there are viable treatments and interventions available to alleviate the suffering,” whereas in Canadian law, the premise is that the patient is the sole arbiter.

Further, as will be explored in another brief in this series, the Benelux countries have committees specifically to review euthanasia case files, to monitor and enforce compliance. Canada lacks a national body to do likewise.³⁰

When comparing the wording of the criteria in table 5, note that some variation may be due to translation into English. The Netherlands Euthanasia Review Committees publish English translations of their reports from the original Dutch. The Belgium and Luxembourg laws were consulted in French. For jurisdictions in which the laws were published in neither English nor French, third-party or Google Translate translations were used, and academic literature in English was also reviewed to confirm our word choices.

27 Scott and Scott, “Suffering as a Criterion,” 211, 214.

28 Mishara and Kerkhof, “Canadian and Dutch Doctors’ Roles,” 727.

29 Mishara and Kerkhof, “Canadian and Dutch Doctors’ Roles,” 727-28. These authors cite a report available in Dutch: Onwuteaka-Philipsen et al., “*Derde evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij Zelfdoding*,” 2017.

30 See also Kotalik, “Medical Assistance in Dying”; Lyon, “Canada’s Medical Assistance in Dying System.”

Table 5. Eligibility Criteria for Assisted Dying: Non-Terminal Suffering

Jurisdiction	Eligible type of suffering	Prospect of alleviation?	Reasonable alternatives?	Who determines reasonable alternatives
Austria	Persistent or permanent symptoms in a severe illness	No, cannot be alleviated	Patient must be informed of alternatives by a palliative care doctor.	Patient only.
Belgium*	Constant and unbearable physical or psychological suffering	No, cannot be alleviated	There must be no reasonable alternatives.	Doctor together with patient.
Canada	Enduring and intolerable physical or psychological suffering	Ambiguous—cannot be alleviated under conditions the person considers acceptable	Patient must be informed of alternatives; no treatment or alternatives need be tried.	Patient only.
Luxembourg	Constant and unbearable suffering, “hopeless” (<i>sans issue</i>) medical condition	No, cannot be alleviated	Patient must be informed of possible treatments and of palliative care available by doctor.	Doctor’s belief as to the patient’s view of no acceptable solution.
Netherlands*	Unbearable suffering; not only physical but also due to “growing dependence, or feeling of humiliation and loss of dignity” or fear of “progressive degradation of quality of life”	No, cannot be alleviated	Patient must be informed of alternatives. Alternatives must be given preference if they can end or considerably reduce the patient’s unbearable suffering.	Doctor together with patient.
Spain	Severe, chronic and disabling suffering	No, cannot be alleviated	Patient must be informed of alternatives.	Patient only.
Uruguay	Unbearable suffering	Unclear	Patient must be informed of alternatives.	Unclear. Likely patient only.

*In Belgium and the Netherlands, the interpretation of reasonable alternatives and degree of deferral to patients in this matter can vary. See for instance, Raus et al. “Euthanasia in Belgium” and the Regional Euthanasia Review Committees, Government of Netherlands, *Annual Report 2023*, 36-39.

Note: Only jurisdictions in which a terminal diagnosis is not required are included in this table.

Sources: See reference list at end of report.

Mental Illness as Sole Underlying Condition

Assisted dying for those whose sole underlying condition is a mental illness is available in a small number of jurisdictions (table 6). Canada is set to join them as of March 17, 2027.

In some jurisdictions that do not allow assisted dying in such cases, patients with a mental illness may still receive an assisted death, so long as they qualify on another basis. The degree to which jurisdictions take steps to screen out persons who may be requesting an assisted death due to their mental illness varies; these safeguards will be discussed in a later brief in this series.

Canadian Context

In Canada, the possibility that mental illness would affect requests for MAiD was a concern of both the courts and the parliament. As researcher Alexander Raikin has noted, the 2012 and 2015 court decisions and the original 2016 legislation created an expectation that safeguards would be able to screen out those seeking MAiD because of a mental illness.³¹ Raikin points to Canadian data demonstrating a feeble screening process.

The situation became more complicated with the expansions passed into law in 2021, when Canadians without a “reasonably foreseeable death” could also become eligible. Initially, the 2021 legislation that was passed in the House of Commons explicitly excluded from eligibility those with mental illness as a sole underlying condition, but the Senate added a sunset clause whereby this exclusion would expire in 2023.³² The expiration date was subsequently pushed back to March 2024, and then to March 2027.³³ A joint parliamentary committee reconvened in February 2026 to evaluate the matter.

31 Raikin, “In Contrast to Carter,” 22-23.

32 Bill C-7, at Section 1 (2.1) and Section 6. For the original text of the bill, prior to the Senate amendment, see First Reading, October 5, 2025, Summary (b).

33 Bill C-39; Bill C-62.

Table 6. Eligibility Criteria for Assisted Dying: Mental Illness as Sole Underlying Condition

Jurisdiction	Eligible based on mental illness as sole condition?
Australia (relevant states)	No
Austria	Unclear
Belgium	Yes
Canada	Yes as of March 2027 ¹
Luxembourg	Yes ²
Netherlands	Yes
New Zealand	No
Spain	Yes ³
United States (relevant states)	No

¹The Provinces of Quebec and Alberta have preemptively blocked the availability of MAiD for mental illness as a sole underlying condition.

²No cases of psychiatric euthanasia have been reported in Luxembourg, according to reports of the Commission Nationale de Contrôle et d'Évaluation de l'application de la loi du 16 mars 2009 sur l'euthanasie et l'assistance au suicide. See *Septième rapport*, 22 and *Huitième rapport*, 9, 19.

³Not explicit in the law but understood to be included. See Albarracín et al.; Arimany-Manso and Martín-Fumadó; and Ramos-Pozón et al. Sources: See reference list at end of report.

Conclusion

This cross-country comparison of the eligibility criteria for assisted dying illustrates important differences between jurisdictions. The most significant of these is whether a terminal diagnosis is required, as is the case in Australia, New Zealand, and the United States, in which the patient must generally have a prognosis of 6 or 12 months or less to live.

The other model, which is followed by the Benelux countries and Canada, is based solely on evaluating suffering, determining whether suffering is intolerable, what alternatives are available, and whether the alternatives must be tried. Even within this group, Canada stands out as unusually permissive, since most Benelux countries require physician involvement in determining if alternatives have been tried, and these alternatives must be given preference if they can reduce the patient's suffering. The Canadian MAiD regime leaves the patient as the sole arbiter of their own suffering and requires only consideration, not trial, of alternative solutions. This makes Canada's regime extremely permissive, and may help to explain Canada's very high incidence of MAiD deaths in relation to total deaths.³⁴

Unlike in Belgium and the Netherlands, MAiD is not available to minors in Canada, nor is it available to patients whose sole underlying condition is a mental illness. Eligibility for patients whose sole underlying condition is a mental illness remains in the legislation, and this provision will come into effect in 2027, unless it is repealed or deferred once more.

34 See Raikin "From Exceptional to Routine" for an international comparison of the numbers.

References

References are listed by jurisdiction, in alphabetical order, and broken out by sub-national jurisdiction when relevant. References that discuss more than one jurisdiction are placed in a final section, titled “Other.”

Reporting on the operation of assisted dying (i.e. statistical data summaries, annual reports, quarterly reports, etc.) are cited throughout the report. A general reference for each jurisdiction’s reporting is included when applicable, through which individual reports can be identified by year.

Australia

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