Briefing from the Royal College of College of Psychiatrists for MPs |
The Terminally Ill Adults (End of Life) Bill for England and Wales |
Report Stage & Third Reading | 16 May 2025

About the Royal College of Psychiatrists

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers from training through to retirement, and in setting and raising standards of psychiatry in the United Kingdom. We work to secure the best outcomes for people with mental illness, intellectual disabilities and neurodevelopmental conditions by promoting excellent mental health services, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of psychiatry.

Introduction

This briefing contains our expert clinical insight for your information ahead of this week's debate and vote in the House of Commons.

This document reflects the position of the Royal College of Psychiatrists on the Terminally Ill Adults (End of Life) Bill for England and Wales. It does not represent a position more broadly on the practice of assisted dying/assisted suicide nor on proposals currently before parliaments in other jurisdictions.

We have arrived at the views expressed within this document after extensive consideration by our assisted dying/assisted suicide working group, surveying and engaging with our members, and discussions with MPs, Peers and colleagues in other jurisdictions.

Key messages

The Royal College of Psychiatrists cannot support the Terminally Ill Adults (End of Life) Bill for England and Wales as it stands.

Specifically, we hold the following views in relation to the Bill:

1. Terminal illness is a risk factor for suicide.
2. There should be a requirement for a holistic assessment of unmet need.
3. Assisted dying/assisted suicide is not a treatment.
4. The Mental Capacity Act does not provide a framework for assessing decisions about ending one's own life.
5. It is not clear what a psychiatrist's role on a panel would be.
6. There are not enough psychiatrists to do what the Bill requires.
7. Professionals must be able to conscientiously object to involvement in any part of the process.
8. Robust professional standards and oversight would need to be in place.
9. Physical effects of a mental disorder should not make a person eligible for assisted dying/assisted suicide.

These statements are elaborated on in nine short sections in the pages that follow.

Terminal illness is a risk factor for suicide.

A terminally ill person is more likely to be depressed. There is significant overlap between the terminally ill population and those who are suicidal – these are not population groups that can be neatly separated.

As the voice of psychiatry, and an organisation that has campaigned for decades to prevent people from dying by suicide, it is important that we directly acknowledge that the passing of this legislation would result in amendments to the Suicide Act. What, then, would this mean for suicide prevention efforts among the terminally ill population in England and Wales?

A duty of care is imposed on clinicians to protect the safety and wellbeing of their patients, including those who are at risk of self-harm or suicide, by the Mental Health Act ("MHA"), the Mental Capacity Act ("MCA") and the Human Rights Act. Should the Terminally Ill Adults (End of Life) ("TIA") Bill become law, it needs to set out clearly how and at what point a practitioner would be deemed to have discharged this duty under existing legislation and codes of practice, while also acting in accordance with this Bill.

Currently, both national suicide prevention strategies for England and Wales identify physical illness as a risk factor for suicide that warrants intervention. Pain from unresolved physical symptoms can make a person want to die, as can fear of physical pain or death. Depression, which is often missed, is also strongly associated with a wish to die. But if a terminally ill person's physical pain or associated fear of it is alleviated, or their depression found and treated, this wish to die often dissipates.

There should be a requirement for a holistic assessment of unmet need.

If a person has needs that are not being met, they are more likely to want to die. Is the person in intolerable pain? Do they have access to good palliative care, social care and mental health services close to their home or community and for as long as they need it? Are they living in substandard housing or facing financial hardship? Have they experienced a recent personal loss or bereavement? Are they mentally ill? Are they depressed? Do they feel lonely, socially isolated or like a burden? Do they have spiritual care needs? Many of these things, alone or together, can make a person's life feel unbearable.

The TIA Bill requires the coordinating doctor, independent doctor, and multidisciplinary panel to be satisfied that a person has the capacity to make the decision and a clear, settled and informed wish to end their own life, free from coercion. It does not, however, suggest or require that a biopsychosocial assessment of unmet need be carried out at any stage, nor that information is gathered from other professionals involved in a person's care nor from people in their personal life. This means that a person with remediable or treatable needs that may be influencing their wish to end their own life could still be deemed to be making a capacitous, free, clear, settled and informed choice free from coercion.

It is good clinical practice to carry out a comprehensive holistic assessment of a patient so that they can be supported to effect the outcome that they want, and which is in their best interests. By looking at biological, psychological and social elements of a person who wishes to die, there is an opportunity to identify remediable and treatable aspects of their situation or symptom experience.

Assisted dying/assisted suicide is not a treatment.

This Bill is about the decisional right to end one's own life in terminal illness via the self-administration of lethal medications which have been prescribed by a doctor. While it is clear that what is being assessed is a person's capacity to decide to end their own life, the TIA Bill does not specify whether assisted dying/assisted suicide ("AD/AS") is a treatment option.

This ambiguity has major implications in law and for the role of psychiatrists; where similar legislation has remained ambiguous on this point in other jurisdictions – such as in Victoria, Australia – codes of practice have relied on decision-making tools which were developed specifically for treatment decisions.

The Secretary of State for Health and Social Care and Welsh Ministers have legal duties to "promote a comprehensive health service designed to secure improvement in the physical and mental health" of the population and "in the prevention, diagnosis and treatment of mental and physical illness." Should these roles be responsible for an intervention which is:

- not a treatment but requires pharmacological intervention; and
- sought expressly for the purpose of ending a person's own life?

AD/AS is not an intervention that can be neatly categorised or indicated for within existing clinical systems or ethical concepts. It is not one which aims to improve a person's health. Its intended consequence is death. What is before people considering AD/AS is an existential choice about a life-ending intervention as opposed to a treatment option aiming to improve health. Should this Bill proceed, it should specify and be explicit that AD/AS is not a treatment option.

The Mental Capacity Act does not provide a framework for assessing decisions about ending one's own life.

The MCA was created to safeguard and support people who do not have the mental capacity to make decisions about their care or treatment, or other matters like finances. It provides professionals with a framework to assess a person's capacity to make decisions that are in their best interests around things like changing residence or getting surgery. The MCA does not provide a framework to determine a person's capacity to decide to end their own life.

Comparisons have been made between the TIA Bill's novel capacity test and assessments of capacity that are currently carried out under the MCA when a person wishes to withdraw from or refuse life-sustaining treatment. Throughout this process, we have observed philosophical arguments about acts versus omissions, but what is functionally important for the capacity test in this example is that a refusal involves choosing not to receive a treatment. There is a clear distinction between not keeping a terminally ill person alive and ensuring that they are as comfortable as possible at the end of their life versus the active administration of lethal medications.

Were this Bill to proceed, implications for the MCA would need to be considered – how would we assess the new kind of capacity framed in the TIA Bill? Implications for the MHA would also need to be considered – how would we protect and empower people with terminal illness to decide whether or not to end their own life, while at the same time detain those who are at risk of suicide so that they can be urgently treated? For coherence, legislative attention needs to be given to these three laws – the MCA, MHA and TIA Bill – together.

It is not clear what a psychiatrist’s role on a panel would be.

This Bill proposes that psychiatrists be involved in two main ways: through assessments of mental capacity as part of routine psychiatric practice and in a safeguarding role on a panel. The role of a psychiatrist on the panel in the TIA Bill as drafted appears to be to review the decisions of the assessing doctors, rather than assess for mental disorder which impairs capacity or unmet mental health need; this does not align exclusively with the skills and expertise of the profession.

Psychiatrists have expertise in the diagnosis and treatment of mental disorders and the impact of those disorders on decision making. While psychiatrists do sometimes advise other health professionals in instances when they are unclear about a person’s decision-making capacity, a psychiatrist’s role and clinical expertise is predominantly in psychiatric interventions in the context of a person’s care and treatment; capacity assessments for the purposes of the MHA; and in determining whether a person with a mental illness, intellectual disability or neurodevelopmental condition can consent to their treatment.

If this Bill proceeds, any role a psychiatrist plays in an AD/AS process should be consistent with the core duties of the profession, including determining whether someone is experiencing something that is contributing to their wish to die that can be remedied or treated. It would also be important to ensure that the appropriate intervention to address an unmet need is available should an AD/AS service be introduced – simply identifying that there are remediable or treatable needs that may be influencing a person’s wish to end their own life is not enough.

There are not enough psychiatrists to do what the Bill requires.

We must look at what is being proposed within the context of rising demand for mental health services. There has been a significant rise in mental ill-health, driven by an increase in risk factors – poverty, housing and food insecurity. As things currently stand, mental health services simply do not have the resource required to meet a new range of demands.

Among the trusts and local health boards across England and Wales that responded to our most recent workforce census, almost 1 in 6 consultant psychiatrist posts were vacant or unfilled. Based on NHS targets to expand the workforce, there is a shortfall of almost 700 consultant psychiatrists across England alone. We are pleased to see that the Bill now requires assessments to be undertaken, and information provided, in Welsh when that is a person’s first or preferred language, but this too carries with it resource implications.

Expected reforms to the MHA will also require more of the consultant workforce. Its Second Opinion Appointed Doctor system is being expanded significantly, but it is already stretched and largely made up of retired psychiatrists. Is it expected that the panels that the TIA Bill would create would also draw on this workforce? Where will the extra consultant psychiatrists to fill these roles come from? What kind of experience will be needed?

Whether this Bill proceeds or not, the capacity of the psychiatric workforce in England and Wales needs to be expanded.

Professionals must be able to conscientiously object to involvement in any part of the process.

We are pleased to see that the Bill no longer requires medical professionals who do not wish to be involved to refer a person to another clinician. However, we note that, if asked about AD/AS by a patient, professionals are required to direct a person to where they can obtain information on how to have a preliminary discussion.

For some psychiatrists who wish to take no part in such a service, this would constitute being involved in the process. Although an equal proportion of psychiatrists who responded to our survey indicated opposition (45%) and support (45%) respectively for AD/AS for people with terminal illness, most respondents (58%) said that they would not be willing to participate as a medical professional. It is therefore important that all clinicians, including psychiatrists, are afforded the right to not take part in an AD/AS service for any reason, including those who conscientiously object on professional, moral, religious or spiritual grounds.

In cases where a person clearly does not meet the eligibility criteria, the TIA Bill does not set out the extent to which a psychiatrist would have to comply with a patient's wish to progress to a preliminary discussion. What would the requirement to provide information mean for a patient of a psychiatrist who clearly does not meet the eligibility criteria and whose primary reason for asking to end their own life is a mental disorder? Were this Bill to proceed, this point should be clarified within it.

A psychiatrist's ability to form and maintain a therapeutic relationship with a suicidal patient could be detrimentally impacted if they were required to provide information on an AD/AS service when asked in every single case.

Robust professional standards and oversight would need to be in place.

If an AD/AS service is introduced, standards of existing psychiatric practice must not be compromised. Any professional involved in assessments for AD/AS would need to be adequately experienced, trained, and independently overseen. There would need to be arrangements in place for the regulation of their practice, supervision and appraisal. Access to peer group dialogue would also be important.

If capacity assessments for AD/AS become part of normal psychiatric practice, it is likely that a small proportion of psychiatrists will actively opt to undertake most of such assessments. Like existing aspects of psychiatric practice, quality needs to be monitored and assured, and training built into the process. Particular consideration would need to be given to the values of the psychiatrist and the relationship between the clinician and the person being assessed to ensure it was free of bias and did not impact the outcome.

Few psychiatrists will already have the experience of the patient group that is required to fully understand their needs. Small numbers of psychiatrists work in hospices and palliative care; psychiatrists in hospitals work with people with life limiting illnesses, and old age psychiatrists with people in the final years of their life. Most psychiatrists do not work with this patient group. For autistic people or people with intellectual disabilities, a psychiatrist with further specialist experience would be required.

We learn and develop professional practice by scrutiny and peer review. Capacity assessments and panel decisions need to be recorded, in all cases regardless of outcome.

Physical effects of a mental disorder should not make a person eligible for assisted dying/assisted suicide.

A key feature of some mental disorders – such as eating disorders, dementia, and alcohol and substance dependence – are physical characteristics and symptoms. While the Bill states that a person is not considered terminally ill only because of a mental disorder, it is silent on how the eligibility criteria are to be applied to people who are experiencing the physical effects of such conditions.

Under this Bill, a person could be deemed eligible based on severe physical complications of a mental disorder which would result in death if left untreated. Malnutrition caused by anorexia nervosa, for example, has been deemed as a terminal illness under similar pieces of legislation in other jurisdictions. However, in England and Wales, eating disorders can currently be treated under existing mental health legislation, even when an individual would rather die than gain weight; such thoughts, while genuine, are often a symptom of the illness and frequently diminish with treatment.

Physical consequences of mental disorder can also impair capacity in ways that are difficult to detect. Starvation, for example, can cause memory problems and significantly impact the way a person weighs information.

If the TIA Bill were to proceed, it would be essential to include provision within it for excluding the physical effects of mental disorder as the basis for eligibility. To not do so would risk the erosion of trust in psychiatric care and the normalisation of therapeutic nihilism in the face of severe illness.

More information

If you have any questions or require further information, please contact Gregory Kay, Public Affairs and Media Officer at gregory.kay@rcpsych.ac.uk. We would also be delighted to arrange a meeting at a convenient time for you, either in person or virtually, if you would like to discuss any issues raised in this briefing in more detail, now and in the future.