Briefing and recommendations from the Royal College of Psychiatrists
The Terminally Ill Adults (End of Life) Bill for England and Wales
The House of Lords | October 2025

Introduction

Background

Prior to the Third Reading of the Terminally Ill Adults (End of Life) Bill for England and Wales in the House of Commons, we were clear that we could not support the Bill in its current form due to our ongoing concerns. Now that the Bill has reached the House of Lords, there is an important opportunity at this stage of the parliamentary process to improve it so that the Bill better protects vulnerable patients and aligns with the roles and core duties of psychiatrists.

The Royal College of Psychiatrists (RCPsych) does not take a position on the principle of assisted dying/assisted suicide[1] (AD/AS) nor on whether Westminster should pass legislation to introduce an AD/AS service.[2] The views expressed in this document follow extensive consideration by our AD/AS working group, surveys and engagement with our members, and discussions with Parliamentarians and colleagues in other jurisdictions. Our recommendations take account of national and international research on the mental health needs of terminally ill populations. Psychiatry is a pluralistic profession; while this document represents a general consensus on the Bill before Westminster, we recognise that there are a range of views among our members, reflecting the complexity and sensitivity of this issue.

Our submission

Psychiatrists are medically qualified doctors with specialist training and expertise in the mental and physical manifestations of psychological and behavioural disorders. We treat and support people with mental disorders (including severe and enduring mental illness, mood disorder, dementia and substance use), intellectual disabilities, neurodevelopmental conditions and neuropsychiatric conditions to manage or recover. Therefore, our submission focuses on two main areas:

1. the possible impact of proposed AD/AS legislation on people with, or the potential to develop, mental disorders, intellectual disabilities, neurodevelopmental conditions and neuropsychiatric conditions; and
2. the role of psychiatrists in the proposed AD/AS legislation.

This document is split into two sections. The first section centres on fundamentals of assessment which should be foundational to any proposed AD/AS legislation for England and Wales. The second section looks specifically at parts of the Bill for England and Wales that are not consistent with these fundamentals, or where it is not clear whether this is the case.

This submission does not comment on the setting in which an AD/AS service should sit or where and by who such a service should be provided, nor on the appropriateness or inappropriateness

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[1] There is no consensus within or without the RCPsych about a single term that should be used when discussing the practice of assisting people to end their own lives. Terms vary in meaning and interpretation, and include 'assisted dying,' 'assisted suicide,' 'medical assistance in dying,' 'physician assisted suicide,' 'voluntary assisted dying' and 'voluntary euthanasia.' We have elected to use the term 'assisted dying/assisted suicide,' or 'AD/AS' hereafter. The use of this term is intended to reflect the lack of consensus on the most appropriate description of the practice.

[2] The size of the psychiatric workforce would need to be expanded to meet the requirements of an AD/AS service. As things currently stand, mental health services simply do not have the resource required to meet a new range of demands.

of other professionals' roles (or lack thereof) in this process. Our submission also does not go into detail about how to safeguard against coercion, as although psychiatrists can contribute to the detection of coercion in their own patients, we do not have particular specialist expertise in this area. We do wish to note, however, that coercion – including indirect or internal forms of pressure, fear of being a burden, financial hardship and inadequate social support – needs to be comprehensively assessed. No assessment can definitively rule out coercion, but it can improve the likelihood that coercion is detected.

Our recommendations are aimed at making the Bill safer for our patients, but we recognise that risk cannot be eliminated completely given the complexities involved with assessing for mental disorder and capacity in people nearing the end of life.

Suicide prevention

For decades, the RCPsych has campaigned to prevent people from dying by suicide. The passing of this Bill would reflect a belief by Parliament that a person with a terminal illness can rationally choose to end their own life and, if deemed capacitous, that they should be assisted in their voluntary decision to die. Whether this Bill passes or not, suicide prevention remains a duty when someone is terminally ill as it is for all people.

Section 1: Fundamentals of assessment for assisted dying/assisted suicide applicants

1. Assessment structure

Holistic & multidisciplinary

A primary purpose of a holistic assessment should be to identify and offer input or treatment for remediable factors which may be influencing an applicant's wish to hasten death and their decision to apply for AD/AS, including (but not limited to) pain and other distressing physical symptoms; depression or other mental disorder; inadequate access to services (palliative care, social care and mental health services); housing or financial difficulties; and social isolation.

An individual applying for AD/AS should be assessed holistically, with multidisciplinary consideration by professionals who have expertise relevant to their circumstances and illness experience. If identified, the appropriate intervention(s) to address an unmet mental health need should be made available to the applicant. Where an applicant is already receiving palliative care, it would be important to make sure that they have access to psychological support, including psychiatric assessment and treatment where needed before proceeding further. It would also be important to ensure a person's spiritual needs are being met.

Face-to-face and comprehensive

All assessments of people with mental disorders, intellectual disabilities, neurodevelopmental conditions and neuropsychiatric conditions should take place in person through face-to-face assessments, unless remote geography renders this impossible. When a psychiatrist is involved in assessments for AD/AS, they should be a consultant on the GMC specialist register.

Assessors should be required to take all practicable steps to work with professionals involved in a person's health and social care, and to talk to a relative, carer or nominated friend, including by accessing medical notes from both primary and secondary care.

It is essential that applicants whose first language is not English are able to access assessments, information and interpretation in their preferred language, and with appropriate religious and cultural understanding and support. To this end, the shortage of Welsh-speaking psychiatrists would need to be addressed should an AD/AS service be introduced in Wales.[3]

2. Psychiatric components of assessment

Identification of psychological and behavioural disorders

As psychiatrists, we wish to emphasise the complex nature of mental disorders, intellectual disabilities, neurodevelopmental conditions and neuropsychiatric conditions, and their interplay with physical, social and spiritual health. The difference between symptoms of mental illness and the psychological distress associated with terminal illness can be difficult to distinguish, as can ensuring that any decisions made are free from the influence of impaired mental health.

Evidence shows that depression is far more common in terminally ill populations. Depression is strongly associated with a wish to hasten death, but this wish is frequently reduced when treated.[4]

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[3] We acknowledge that this would be for the Welsh Government and Senedd to take forward, rather than for representatives in other jurisdictions.

[4] Price, A., Lee, W., Goodwin, L., Rayner, L., Humphreys, R., Hansford, P., Sykes, N., Monroe, B., Higginson, I., & Hotopf, M. (2011). Prevalence, course and associations of desire for hastened death in a UK palliative population: a cross-sectional study. *BMJ supportive & palliative care, 1*(2), 140–148. https://doi.org/10.1136/bmjspcare-2011-000011

Nature of intervention and assessment of mental capacity

AD/AS is personal choice about the decision to end one's own life. While eligibility requires clinically informed assessment and intervention as part of the process (through assessment of terminal illness, assessment of mental capacity, and prescription of a lethal substance), the prescription of a lethal substance itself cannot aim to improve a person's health or quality of life as its intended consequence is death. In this respect, AD/AS cannot be categorised within conventional clinical systems or medical ethics concepts as a treatment. When assessing mental capacity for AD/AS, professionals would not be disclosing information about different options of recommended treatment (the conventional medical role) because the option of AD/AS is a personal choice not a treatment.

It is however important to recognise that this personal choice might be made in response to unmet psychological or spiritual needs at the end of life. This is why it is vital that a person is offered all appropriate psychiatric, psychological, social and spiritual assessments and interventions.

Specialist training and ongoing supervision arrangements would be required for professionals so that they are able to conduct appropriate assessments of whether a person has a mental disorder and the capacity to decide to end their own life.

3. Role of the psychiatrist

In a well safeguarded process, a person should not access AD/AS if they would have made a different decision had they received effective treatment for a mental disorder affecting their decision-making. To this end, we expect that psychiatrists would be involved in an AD/AS service in two ways:

1. the identification and treatment of unmet psychiatric need; and
2. supporting assessments of capacity to decide to end one's own life.

Expertise

Psychiatrists can only work within their professional competencies and expertise, and should not be required to do any aspect of assessment for which they are not appropriately trained or skilled.

Supporting staff and protecting against unconscious bias

Unconscious motivation can influence the decisions of both patients and doctors about a matter such as ending one's own life. Professionals involved with AD/AS should have access to structured space for reflection, supervision, and training in recognising unconscious dynamics. This is essential to prevent unconscious collusion, safeguard patients and clinicians, and support balanced decision-making.

4. National monitoring

Decisions relating to a person's application should be recorded nationally and publicly reported by a central government agency in all cases regardless of outcome. By knowing how many applications are rejected and for what reasons we would learn more about people requesting AD/AS.

For example, understanding more about applications rejected on the grounds of incapacity would aid in scrutinising whether capacity determination is sufficient as a safeguard. Similarly, it would be important to record demographic information and the reasons or contributing factors for a person's application.

Section 2: Concerns about the Terminally Ill Adults (End of Life) Bill for England & Wales

There are aspects of the Terminally Ill Adults (End of Life) Bill which do not align with the fundamentals of assessment set out in section one. The Bill could be improved by addressing the recommendations in this section.

Further to the recommendations set out in this section, there needs to be detailed consideration given to the potential impacts on mental health services and people with mental illnesses in the event that:

1. legislation is commenced at different times in England and in Wales; or
2. the Senedd does not grant legislative consent to the Bill, meaning AD/AS could become legal in Wales but without a service being made available by the state.[5]

Scope of eligibility

What does the Bill currently say?

The Bill states that "**a person is not to be considered to be terminally ill only because they are a person with a disability or mental disorder (or both)**." However, the Bill is clear that a terminally ill person with a disability or mental disorder could still be deemed eligible if they were judged to be capacitous and met all other eligibility criteria.

What is the concern?

The Bill does not explicitly exclude a person from being deemed eligible for AD/AS on the basis of the physical effects of a mental disorder. This means that a person with a mental disorder which could reasonably be expected to cause their death within six months and who is not responding to treatment – such as a person with organ damage from the effects of severe anorexia nervosa or from the effects of a substance use disorder – could be deemed eligible for AD/AS.

How could this be improved?

Recommendation 1: Include an explicit provision within the Bill which excludes the physical effects of mental disorder as the basis for eligibility.

Opt-in requirements

What does the Bill currently say?

If an assessing doctor refers their patient to a psychiatrist for a capacity assessment, then the Bill states that the psychiatrist must be "**a registered medical practitioner who is a practising psychiatrist registered in one of the psychiatry specialisms in the Specialist Register kept by the General Medical Council or who otherwise holds qualifications in or has experience of the assessment of capacity.**"

The Bill states that no "**person is under any duty to participate in the provision of assistance in accordance with this Act**" and that no "**registered medical practitioner is under any duty to become [...] the coordinating doctor [...] or [...] the independent doctor in relation to any person.**" It also states that no "**health professional or social care professional is under any duty to respond when consulted**" by an assessing doctor.

[5] Notwithstanding this potential scenario, we consider the Welsh Ministers' powers under section 42 to be constitutionally appropriate.

What is the concern?
New professional standards for the practice and oversight of psychiatrists who are undertaking roles for the purposes of this legislation would need to be developed for what would be an entirely new area for psychiatrists in England and Wales. Currently, the Bill contains no provisions for a central register of professionals willing to opt in or any outline of how it would enable appropriate professional oversight as we have in existing areas of professional practice.

The Bill does not state whether AD/AS is to be considered a treatment or not. Should AD/AS be considered a treatment option, psychiatrists working therapeutically with terminally ill patients may be required to take a view about whether or not they should recommend AD/AS, just as they may currently choose to recommend existing treatments or pathways of care. This could impede a psychiatrist's ability to establish a therapeutic relationship with the patient and continue to treat the person. As the Bill is currently drafted, psychiatrists could face serious professional consequences if it were considered that they failed to adequately inform a patient about AD/AS alongside existing treatment options.

How could this be improved?
Recommendation 2: Clarify that assisted dying/assisted suicide is not a treatment (and should not be presented to patients as a modality of treatment) and that there is therefore no professional obligation to raise it with patients.

Recommendation 3: Establish a central, opt-in register of psychiatrists who are eligible and willing to undertake assessments for the purposes of assisted dying/assisted suicide.

Mental health need

What does the Bill currently say?
Clauses 5 and 12 state that the registered medical practitioner conducting a preliminary discussion with a person and the assessing doctors carrying out the first and second assessments "**must explain to and discuss**" with the person their "**diagnosis and prognosis**" and "**any treatment and the likely effect of it**." The practitioner conducting the preliminary discussion must cover any "**appropriate palliative, hospice or other care, including symptom management and psychological support, and offer to refer them to a registered medical practitioner who specialises in such care for the purpose of further discussion**." The assessing doctor must cover "**available palliative, hospice or other care, including symptom management and psychological support, and offer to refer them to a registered medical practitioner who specialises in such care for the purpose of further discussion**."

Clause 12, subsection 3 states that, to "**inform their assessment, the assessing doctor must [...] consider whether they should consult a health professional or social care professional with qualifications in, or experience of, a matter relevant to the person being assessed**." Clause 12, subsection 6 states that the assessing doctor "**must, if they have doubt as to the capacity of the person being assessed, refer the person for assessment**" to a psychiatrist.

Clause 12, subsection 2 (g) states that "**in so far as the assessing doctor considers it appropriate, [they must] advise the person to consider discussing the request with their next of kin and other persons they are close to**."

What is the concern?
Although the Bill states that a person must have all "**appropriate**" and "**available**" care explained to and discussed with them, it does not include a formal requirement for unmet need to be assessed and identified, nor that appropriate care be actually made available to the individual.

This means that a person with a co-occurring mental disorder that was impacting their wish to end their own life who had been deemed eligible could go through the assessment process without necessarily having their unmet mental health need identified nor treatment offered to remedy it.

A person with terminal cancer may have a treatable depressive illness which is influencing their wish to die but still be determined as having capacity to decide to end their own life and therefore eligible. Despair and wanting to die because of fear, shock and complex emotions in the early stages of adjusting to a terminal diagnosis can be an extreme grief reaction to perceived future losses which, given the right support, can change over time. While a person may be capacitous, they also might feel differently at a future time if provided with appropriate interventions and support to treat their co-occurring mental disorder. Our concern is that a multidisciplinary assessment of need (which includes a mental health assessment) and a consideration of suicide protection duties are being bypassed by the Bill in its current form.

Assessors are not currently required to take all practicable steps to work with professionals involved in a person's health and social care nor are they required to try to talk to a relative, carer or nominated friend. This means that relevant information may be missed.

How could this be improved?

Recommendation 4: Require that each applicant is holistically assessed at the stage of preliminary discussion, including for mental health need.

Recommendation 5: Mandate that appropriate and timely treatment is offered to applicants where need is identified.[6]

Mental capacity

What does the Bill currently say?

Clause 3 reads as follows: "**In this Act, references to a person having capacity are to be read in accordance with the Mental Capacity Act 2005.**"

What is the concern?

The Mental Capacity Act (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, providing professionals with a framework to make decisions that are in their best interests. It does not provide a framework to determine a person's capacity specifically to decide to end their own life and it contains principles which we are not certain are applicable to the Bill, such as the presumption of capacity and the principle of best interests.

It is also not made clear how the provisions of the MCA and Mental Health Act relate to each other nor how psychiatrists would adequately discharge their duties within both pieces of legislation in relation to a person requesting assistance to die.

How could this be improved?

Recommendation 6: Formally review the Mental Capacity Act's suitability as a decision-making tool for assessments of mental capacity for assisted dying/assisted suicide applications, and the coherence of such potential decisions with the Mental Health Act.

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[6] Should recommendations 4 and 5 be accepted, the purpose of a panel after the assessment stages of the process would need to be reconsidered as the clinical function of a multidisciplinary assessment will have been discharged earlier in the process.

Unconscious bias

<u>What does the Bill currently say?</u>
The Bill requires that assessing doctors have training about assessing capacity; coercion; reasonable adjustments and safeguards for autistic people and people with a learning disability; and domestic violence.

<u>What is the concern?</u>
The Bill does not require that clinicians involved in the process receive training about the influence of emotions and unconscious motivations on decision-making.

Professionals involved in AD/AS assessments should have access to structured space for reflection, supervision, and training in recognising unconscious dynamics. This is essential to prevent unconscious collusion, safeguard both patients, clinicians and society more broadly, and support humane and balanced decision-making. This should be provided to all professionals involved in assessing applications for AD/AS to ensure they recognise these forces.

<u>How could this be improved?</u>
Recommendation 7: Require assessing doctors to be trained in, and access relevant supervision regarding, how unconscious motivations and biases can strongly influence the decisions of both patients and doctors.

The Panel

<u>What does the Bill currently say?</u>
The Panel's function is stated as being "**to determine whether it is satisfied**" that the Bill's requirements in relation to the first declaration, first assessment and second assessment have been met. Its purpose also includes "**to determine whether it is satisfied**" that the applicant is:

- **terminally ill;**
- **has the capacity to make the decision to end their own life;**
- **has a clear settled and informed wish to end their own life; and**
- **made the first declaration voluntarily.**

The Panel's function in the Bill is therefore twofold, to:

1. scrutinise assessors' decisions by reviewing the available evidence; and
2. conduct its own investigation and consider the applicant's eligibility for itself.

The Bill states that a panel will consist of a legal member, psychiatrist and social worker. The psychiatrist member of the Panel is required to be a registered medical practitioner, a practising psychiatrist and "**registered in one of the psychiatry specialisms in the Specialist Register kept by the General Medical Council.**" The Bill also states that the Panel "**may hear from and may question [any] person**."

<u>What is the concern?</u>
As currently drafted, the Panel does not serve the same function as a multidisciplinary team in clinical practice. Multidisciplinary consideration needs to take place earlier in the process.[7]

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[7] Please see recommendations 4 and 5.

It is not clear whether it is within the Panel's scope to identify and make available treatments for unmet need. This means that if the psychiatrist on the Panel has concerns about the applicant's mental health and unmet need, it is not clear how they would then ensure any assessment takes place. This is particularly concerning given the current lack of any requirement for such an assessment at the preliminary discussion stage.

Currently, a psychiatrist is the only medical professional on the Panel. The Panel is required to satisfy itself that the applicant is terminally ill with a 6-month life expectancy, but this sits outside of the competencies and professional expertise of psychiatry.

Currently, the powers given to the Panel to request information from health and social care services to aid assessments of mental capacity (and assessments of coercion or pressure from other persons) are unclear. This would limit appropriate investigation in more complex cases.

How could this be improved?

Recommendation 8: Clarify whether it is within the Panel's scope to identify and make available assessments and treatments for unmet mental health need.

Recommendation 9: Medical membership on the Panel should include medical expertise that reflects the needs of the patient. When a psychiatrist is present, they must not be the only medical professional on the Panel.

Recommendation 10: Give the Panel clearer powers to call for evidence itself in more complex cases.

More information

If you have any questions or require further information, please contact Peter Hand, Public Affairs and Stakeholder Manager at Peter.Hand@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.