Written evidence submitted by The Royal College of Psychiatrists (ADY0396)

The College and its members

The Royal College of Psychiatrists ("RCPsych") is the professional medical body responsible for supporting psychiatrists. We work to secure the best outcomes for people with mental illness, intellectual disabilities and developmental disorders by promoting excellent mental health services, supporting the prevention of mental illness, training outstanding psychiatrists, promoting quality and research, setting standards and being the voice of our members and the profession. We represent over 20,000 members and work in all four nations of the UK. We also support members internationally.

Response to proposals

Our submission to the Health and Social Care Committee's inquiry into assisted dying is informed by our members.

It is important to note, the RCPsych does not currently have an established position of neutrality, support, or opposition to the practice of assisted dying. In line with our role as the voice of our members and the profession of psychiatry, our submission advises on matters that relate to persons suffering from mental disorders and the determination of mental capacity.

Specifically, our submission covers, in a limited manner, some points of principle expressed by our members and focuses on how the drafting of any future proposals, legislation and implementation plans may require psychiatric input, as well as the potential impacts that operationalising an assisted dying service may have on services psychiatrists operate.

Questions

Question 1. To what extent do people in England and Wales have access to good palliative care?

a. **How can palliative care be improved, and would such improvements negate some of the arguments for assisted dying/assisted suicide?**

People living with a terminal illness are likely to experience significant psychological distress. As such, the provision of psychological care and support is a fundamental part of good palliative care.

A 2021 national, cross-sectional survey of adult patients' access to, and the adequacy of, psychological services in UK hospices shows that access to such care is limited. This research is available here.

We wish to note that improved access to psychological care for people with palliative care needs is required whether or not assisted dying is legalised.

Question 2. What can be learnt from the evidence in countries where assisted dying/assisted suicide is legal?

In countries where assisted dying is legal, psychiatrists may be asked to provide an expert opinion regarding a person's decision-making capacity. However, evidence as to the effectiveness of capacity assessments as a safeguard for assisted dying services is limited.

A 2022 comparison of official reporting across jurisdictions where assisted dying is legal found significant variance in the kinds of information published within officials reports, and that many jurisdictions do not report data measures. This means that reporting on safeguards varies greatly with few measures published in most jurisdictions.

The longest running and most comprehensive data on this topic are from the Oregon Health Authority's Public Health Division. We suggest that the Committee reviews annual reports from Oregon, which show data around who accesses assisted dying in the jurisdiction and why. It can be noted how little data are made publicly available to evidence that safeguards are being used, and are effective.

We wish to note that, whether or not the government moves to legalise assisted dying, it is vital that steps continue to be taken to make the government's ambitions on suicide prevention a reality, including ensuring that people discharged from inpatient units are contacted by mental health services within three days; that all those who have self-harmed are supported with a 'safety plan'; and that people who attend A&E after self-harm receive a psychosocial assessment.

We would expect the Committee carefully consider the provisions that would be necessary to ensure that any potential proposed assisted dying service would not supersede focus on relieving suffering, improving quality of life, or treating mental illness.

Question 3. What are the professional and ethical considerations involved in allowing physicians to assist someone to end their life?

We would expect consideration to be given to the professionals who would be called upon to provide second opinion capacity assessments for assisted dying applications. Psychiatrists on the GMC specialist register have been named in previous iterations of assisted dying Bills in England and Wales as the professional group with the relevant expertise. Should there be an assisted dying service, a psychiatrist may be asked to conduct an assessment of a person's decision-making capacity should the relevant assessing clinician be unable to make this determination themselves. Such an assessment would likely have a direct influence on an assessing doctor's determination of eligibility.

While psychiatrists would not expect to be routinely asked to be involved in determining whether people are able to make a decision about assisted dying, it is important that, for what would be a highly significant assessment, only those with sufficient expertise to make such a decision are utilised and that they can access the appropriate training and support.

We wish to note that any potential assisted dying proposal must afford psychiatrists the right to conscientiously object to undertaking a supporting assessment, such as an assessment of a person's decision-making capacity. We would also expect that anyone who conscientiously objects to participating in such a process be afforded the right to do so, and that this right be extended to all clinicians who may be called on to participate in such a process. A robust opt out process would need to be carefully considered to ensure the obligation to meet assessment requirements falls on the system, rather than an individual clinician.

The process for clinicians who refuse to participate in an assisted dying service needs to be considered. Would, for example, a clinician be obligated to find their own replacement? Consideration also needs to be given to the additional demands that would be placed on mental health services where one or more staff members conscientiously object to participating in the process. In areas with limited specialist staffing, for example, this could create significant issues in providing a capacity assessment in a timely fashion.

Whether a different threshold for capacity would be required than is already in law also needs to be considered. We have included more information on this specific point in our answer to question 7.

Additionally, despite there being an expectation that non-mental health focused clinicians are trained in adults with incapacity legislation, our members have previously reported that there is a general uncertainty around using it that can translate to requests for capacity assessment being made to psychiatrists and other mental health professionals. Consideration, then, would need to be given to any additional training required to ensure clinicians providing assisted dying services are prepared to assess capacity more widely and in scenarios specific to assisted dying.

Focusing on the services in which psychiatrists operate, we expect the impact to fall on mental health services as additional capacity assessments will likely be required. This impact, including implications for staffing, needs to be considered.

Whether clinicians would have an obligation to refer all patients who requested it to an assisted dying service also needs to be considered. In practice, such a requirement may mean that relevant professionals would have to refer any person for an assisted dying assessment if requested to do so, including those who clearly did not meet criteria (for example, those without a life limiting physical illness). A psychiatrist, for example, may be asked to do so by a suicidal adult they are caring for, which may impact a psychiatrist's ability to establish a therapeutic relationship with the patient and treat the person appropriately for a mental disorder, where that treatment might reduce their wish to die. Whether it would be the duty of the clinician to refer every patient who requested it, or if discretion could be used in instances when it was clear that a person did not fulfil criteria, needs to be considered. Whether a clinician would be obligated to find a replacement in such instances also needs to be considered.

Question 4. What, if any, are the physical and mental health criteria which would make an individual eligible to access assisted dying/assisted suicide services?

We do not have a view on the eligibility criteria for an individual to access assisted dying services. We wish to point out, however, that physical conditions commonly co-exist and interact with mental health conditions. Emotional distress is common in people with life limiting illness and is associated with a wish to hasten death.

We also wish to note that, after passing legislation and implementing an assisted dying service, some jurisdictions have subsequently moved to broaden diagnostic criteria to include mental illness. Should mental disorder, mental disability or mental incapacity ever be considered for inclusion in the eligibility criteria for any prospective assisted dying service, we would expect to be consulted on, and participate comprehensively in, this process.

Question 5. What protections could be put in place to protect people from coercion and how effective would these be?

While we do not have a view on what protections should be put in place to protect people from coercion, our members have expressed the view that while clinicians may be able to protect patients from obvious coercion – such as where there is clear evidence of financial gain – it is difficult to do so for more subtle kinds of coercion, such as feeling a duty to request assisted dying because of the burden (real or perceived) being placed on loved ones in providing care. As such, careful consideration needs to be given to safeguards and mitigations that would be necessary.

Question 6. What information, advice and guidance would people need in order to be able to make an informed decision about whether to access assisted dying/assisted suicide services?

At this stage, we do not have a view on what information, advice and guidance people may need in order to make an informed decision about accessing an assisted dying service.

To provide a view on what information people would need to make an informed decision, the RCPsych would need to have sight of the service that was being proposed. We would expect to be consulted on this point should an assisted dying service be proposed in future.

It is well established that depression is common in people with terminal illness including those with a wish to hasten their death. Where depression is associated with a wish to hasten death, evidence available here shows that treating depression can reduce this wish. It is important that people are well informed about how to seek assessment and treatment for common mental health conditions found in life limiting illness, that clinicians have the knowledge and skills to meet these needs and that others involved in the process know how people can access the right care.

Question 7. What capabilities would a person need to be able to consent to assisted dying /assisted suicide?

Further to our answer to question 3, the degree of capacity required to make such a decision needs to be carefully considered. As there is little published about the practice of capacity assessment in this context internationally, it is difficult to gain a detailed understanding of the process and practice of clinicians in jurisdictions with assisted dying services.

The threshold for capacity determination for assisted dying would influence how rigorous and detailed such an assessment would be. Capacity determination might range from being based on a tightly defined cognitively based assessment to a much broader and more wide ranging assessment, which might include offering challenge or alternatives to assisted dying and examining individual motivations. We would expect there to be rigorous thinking around what capacity determination would comprise. We would also expect that for such a key safeguard, the threshold and process of capacity determination be set out in some detail on the face of any future Bill, as opposed to being considered later in the subsequent code of practice.

A 2014 study exploring concepts of mental capacity for patients requesting assisted dying by examining evidence given to the 2010 Commission on Assisted Dying is available here. This study examines evidence presented by experts to the Commission in relation to mental capacity determination and highlights the diversity in concepts of capacity even within an expert group.

Question 8. What should the Government's role be in relation to the debate?

We note that it is the government's role to make a decision about whether or not it moves to legalise assisted dying. Should the government wish to do so, its role would be to ensure that appropriate safeguards are put in place, and that the health care system, including the mental health care system, is optimised and sufficiently funded.

We would expect that the government ensures that excellent and widely available biopsychosocial palliative care is accessible so that people with life limiting illness have access to the care they need.

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