Evidence submission from the Royal College of Psychiatrists
Review into the proposed Assisted Dying Legislation for Jersey
Assisted Dying Review Panel | States Assembly | November 2025

Introduction

Background

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 the States Assembly 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 elected representatives and colleagues in other jurisdictions. Psychiatry is a pluralistic profession; 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.

Our submission therefore focuses on 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 the role of psychiatrists. This document centres on fundamentals of assessment which should be foundational to any proposed AD/AS legislation for Jersey.

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 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.

Suicide prevention

For decades, the RCPsych has campaigned to prevent people from dying by suicide. The passing of AD/AS legislation would reflect a belief by the States Assembly 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 legislation passes or not, suicide prevention remains a duty when someone is terminally ill as it is for all people.

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[1] There is no consensus 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.' The use of this term 'assisted dying/assisted suicide' 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 in Jersey 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.

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.

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.[3]

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

[3] 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

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.