* **People with terminal illness and people living with mental distress are not mutually exclusive groups. We die too**

We also die earlier, largely due to preventable physical illnesses.[[1]](#footnote-1) People living with “Severe Mental Illness” face one of the greatest health equality gaps in England. Our life expectancy is 15–20 years shorter than that for the general population. We are also more likely than non-Disabled people to be socially isolated and to live in poverty. Research has shown that financial reasons for seeking assisted suicide are climbing among patients in Oregon.[[2]](#footnote-2) Current government plans are specifically targeting those living with severe mental distress for dramatic disability benefit cuts.[[3]](#footnote-3) There is evidence from jurisdictions where euthanasia and assisted suicide [EAS] are legal of people exaggerating their physical symptoms to access EAS when motivated by factors such as depression, loneliness and homelessness.[[4]](#footnote-4)

* **Introducing a system for assisted suicide will divert resources at a crucial time**

Our mental health services are part of a broken NHS. They desperately need extra investment in order to meet both existing need and escalating demand.[[5]](#footnote-5) Introducing physician assisted suicide will require investment. We are concerned that this will divert resources from priority areas and delay fixing a mental health system where avoidable patient deaths are now systemic.

* **Non-assisted suicide rates are higher in jurisdictions where physician assisted suicide is legal**

In Oregon, the suicide rate has increased by nearly one-third (32%) since the legalisation of assisted suicide.[[6]](#footnote-6) The impact on non-assisted suicide rates are even more concerning when we consider the context of rising demand for mental health services that far out-strips capacity. Much more needs to be done in this country to tackle suicide prevention. For example, wider understanding about the links between peri-menopause and suicidal ideation/increased suicidal ideation.[[7]](#footnote-7)

* **Mental distress is overlooked in both the proposed bill and in evidence from other jurisdictions**

The proposed UK bill does not require persons undergo a mental health evaluation to assess for co-occurring depression or suicidality, leaving individuals with untreated or undiagnosed mental distress. In Canada, only 6.7% of persons who died by EAS in 2021 were referred for psychiatric assessment prior to their request being granted.[[8]](#footnote-8) In Oregon referrals for psychiatric assessments have decreased considerably from happening in over 31% of cases in the first year, 1998 to just over 1% of cases by 2022.[[9]](#footnote-9) With three-quarters of those seeking assisted suicide reporting loneliness and 60% experiencing clinical depression, it is evident that mental health factors are being overlooked.

* **Disabled women including those living with mental distress are at higher risk of coercion.**

Provisions in the bill are not adequate to safeguard against situations where patients with terminal illness are coerced to end their lives. It is very difficult for even well-trained professionals to spot coercive control. Disabled people are nearly three times as likely to experience domestic violence as non-Disabled people.[[10]](#footnote-10) Groups of women with characteristics linked to certain mental health diagnoses are particularly susceptible to targeting by partners who exert coercive control.

* **The current wording of the bill allows for broad interpretation of “terminal illness,” and people with eating disorders could be deemed eligible.**

Evidence shows that assisted dying laws have led to preventable deaths of young people with eating disorders in multiple countries.[[11]](#footnote-11) At least 60 individuals with eating disorders have died through assisted death, including in jurisdictions where eligibility is restricted to terminal conditions. One-third were women under 30. The proposed UK bill aims to restrict eligibility to terminal illness, but its wording mirrors Oregon’s law, which allows any conditions expected to cause death within six months *if untreated* to qualify. In Oregon, this has allowed non-terminal conditions like diabetes to be considered terminal if the patient elects to forego life-extending treatments such as dialysis. This has led to deaths in cases of anorexia, arthritis, and hernias.

* **There is no guarantee that, once passed, legislation will not be extended to other groups of people through legal challenges.**

Respected, senior human rights lawyers and experts have warned that this is a very real possibility. It would be highly irresponsible to rule out. Many of those personally affected who are lobbying for legalisation will not be covered by the current bill and will push for a widening of its scope to include those “incurably suffering” which can be interpreted to include those living with mental distress. Mental health categories are not static and universally accepted. They can be amended to fit definitions of terminal illness as we have seen with anorexia.

* **Evidence from other jurisdictions shows physician assisted suicide and euthanasia [EAS] disproportionately impacts women.**

A recent systematic review found that 100% of persons with eating disorders who died through assisted death were women.[[12]](#footnote-12) Women also account for the majority (69–77%) of those who request and receive euthanasia for mental distress. In the Netherlands, 76% of individuals diagnosed with a personality disorder who die by euthanasia are women, many with histories of suicide attempts (47%), self-harm (27%), and trauma (36%). Alarmingly, 28% had never received psychotherapy. Given the current challenges in mental health services in England and Wales, extending legislation to cover mental distress would likely lead to a similar pattern.

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