Senedd Member Briefing | 21 October 2025
The Terminally Ill Adults (End of Life) Bill

Introduction

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and setting and raising standards of psychiatry.

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.

This briefing reflects the position of the RCPsych on the Terminally Ill Adults (End of Life) Bill for England and Wales following extensive consideration by our assisted dying/assisted suicide (AD/AS) working group, surveying and engaging with our members, and discussions with parliamentarians and colleagues in other jurisdictions.

College Position

Our members have a diverse range of views on the principle of AD/AS, but in May this year we developed a consensus that we **cannot support the Bill in its current form**.

We recognise that AD/AS is a matter of conscience and therefore do not seek to instruct how Senedd Members should vote. Our intention is to provide evidence-based clinical insight to inform their deliberations, highlighting aspects of the Bill that do not align with key principles of mental health assessment.

Our concerns about the Bill align with nine specific views.

1. **There is a lack of clarity regarding how professionals fulfil their existing duty to prevent suicide and self-harm while also acting in accordance with this Bill:** There is significant overlap between the terminally ill population and those who are suicidal – these are not population groups that can be neatly separated. Should the Bill become law, it needs to set out clearly how and at what point a clinician would be deemed to have discharged their duty of care to those who are at risk of self-harm or suicide under existing legislation and codes of practice.

2. **There should be a requirement for a holistic assessment of unmet need:** Treatable needs such as mental illness, intolerable pain, financial hardship and inadequate care or housing can make a person want to die. Yet, the Bill makes no provision to assess unmet needs at any stage, nor consult others involved in the person's care or life. We believe the Bill should require that each applicant is holistically assessed.

3. **The Bill does not specify whether AD/AS is considered a treatment option:** Should AD/AS be considered a treatment option, psychiatrists might be expected to discuss or recommend AD/AS like other interventions, risking damage to therapeutic relationships and exposing them to professional liability if they do not. This ambiguity

could have serious implications for clinical practice. The Bill should therefore make clear that AD/AS is not a treatment option.

4. **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 capacity to make decisions about their care, treatment or matters like finances. The MCA alone may not be sufficient to safeguard against incapacity and unmet mental health need. We believe the MCA's suitability as a decision-making tool for assessing mental capacity in AD/AS applications should be formally reviewed, alongside the consistency of such decisions with the Mental Health Act.

5. **It is not clear what a psychiatrist's role would be on a multidisciplinary panel:** 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 a person's wish to die can be remedied or treated. Currently, a psychiatrist is the only medical professional on the panel, alongside a legal member and a social worker. The panel is required to satisfy itself that the applicant is terminally ill, but this sits outside of the competencies and professional expertise of psychiatry.

6. **There are not enough consultant psychiatrists to do what the Bill asks:** As things currently stand, mental health services simply do not have the resource required to meet a new range of demands. We must look at what is being proposed within the context of rising demand for mental health services and workforce shortages. We welcome that the Bill has been amended to provide for the provision of information in English *and* in Welsh. However, the shortage of Welsh-speaking psychiatrists must be addressed, as must ensuring appropriate provision for individuals whose first language is neither Welsh nor English.

7. **Professionals must be able to conscientiously object to involvement in any part of the process:** We are pleased that the Bill no longer requires medical professionals who do not wish to be involved to refer a person to another clinician, but they are still required to signpost patients to information on AD/AS. For some psychiatrists who wish to conscientiously object, this would constitute being involved in the process.

8. **Robust professional standards and oversight need to be put in place:** 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. For psychiatry, we believe this means establishing a new, central, opt-in register of psychiatrists who are eligible and willing to undertake AD/AS assessments.

9. **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 – could be deemed eligible for AD/AS. Dying is not the primary motivation for not eating or drinking for this patient group – the reason is an extreme fear of weight gain due to mental disorder. This, therefore, is not a voluntary decision.

Senedd Reports

RCPsych Wales welcomes the reports published the Health and Social Care Committee and the Legislation, Justice and Constitution Committee on the LCMs. We are pleased to endorse all the conclusions and recommendations made, as summarised here.

Health and Social Care Committee

Conclusions

1. The Committee takes a neutral stance on AD/AS, leaving support for the LCMs to individual Members' conscience.
2. Any future Welsh regulations on AD/AS should be issued in draft for full public consultation and detailed Senedd scrutiny, with clear policy aims and costings.
3. Assisted dying must be clearly separated from palliative care, with safeguards to ensure palliative and end-of-life care funding is not affected.

Recommendations

1. The Cabinet Secretary should justify the limited scope of the legislative consent request, given health is largely devolved.
2. The Cabinet Secretary should provide regular updates on workforce planning, including training, responsibilities, Welsh-language capacity, and costs.
3. The Cabinet Secretary should clarify the Voluntary Assisted Dying Commissioner's powers for independent investigations and reporting.
4. The Cabinet Secretary should explain whether a Welsh-specific Commissioner was considered and, if not, why not.
5. The Cabinet Secretary should outline plans to expand Welsh-speaking staff for assisted dying services.
6. The Cabinet Secretary should explain how AD/AS services will meet the needs of people whose first language is not Welsh or English.

Legislation, Justice and Constitution Committee

Conclusions

1. Subject to Recommendation 1, the Committee agrees with the Welsh Government's assessment of which Bill provisions require Senedd consent under Standing Order 29.

Recommendations:

1. The Senedd's consent should be required for clauses 1-31, 34-40, and 42-59 of the Bill.
2. The Cabinet Secretary should explain why the Bill creates a concurrent power in clause 40 that is not subject to a relevant consent mechanism and an associated 'carve out' from the Government of Wales Act 2006.
3. The Cabinet Secretary should confirm that sections 42(1), 42(2), 51(2) and 51(3) may be commenced by the Welsh Ministers only through regulations, and that no automatic commencement backstop applies.

Influencing at Westminster

The College has actively sought to improve and refine the Bill throughout its passage at Westminster.

Most recently, we shared a briefing with Members of the House of Lords ahead of Committee Stage. The briefing comprises two sections: the first outlines key mental health principles that should underpin any AD/AS legislation in the UK; the second highlights areas of the Bill that conflict with or fail to reflect these principles, offering recommendations for improvement.

The briefing can be accessed via the following QR code:

Further information regarding our work on AD/AS can be accessed via the following QR code:

Contact for Further Information

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