RCPsych Wales response to the call for evidence on the Legislative Consent Memorandum for the Terminally Ill Adults (End of Life) Bill

Introduction

The Royal College of Psychiatrists Wales (RCPsych Wales) welcomes this opportunity to respond to the Health and Social Care Committee's call for evidence on the Welsh Government's Legislative Consent Memorandum for the Terminally Ill Adults (End of Life) Bill (TIA Bill).

Although the Committee's questions relate specifically to the provisions contained in that LCM, we also feel a duty to share our wider views regarding the TIA Bill, which cover nine specific points.

These views (set out in Annex 1 to this document) have led RCPsych to conclude that it **cannot support** the Terminally Ill Adults (End of Life) Bill for England and Wales in its current form.

About RCPsych Wales

The RCPsych is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and setting and raising standards of psychiatry. The College aims to improve the outcomes of people with mental illness and intellectual disabilities, and the mental health of individuals, their families and communities.

To achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations.

Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies. RCPsych Wales represents more than 600 consultant and trainee psychiatrists working in Wales.

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Response to the Committee's Questions

Clause 37: guidance about the operation of the Act

Clause 37 of the Bill requires the Chief Medical Officer (CMO) for Wales to prepare and publish guidance about the operation of the Act. Before making guidance, the CMO must consult with relevant individuals and groups, including people with learning disabilities, and ensure the guidance is practical and accessible.

1. What are your views on these proposals?

We are not opposed to this proposal.

2. What are your views on whether these proposals are sufficient to ensure that the Chief Medical Officer for Wales can effectively oversee the implementation of assisted dying services?

Given the roles envisaged for psychiatrists in assessing mental capacity and sitting on Assisted Dying Review Panels, we consider that the CMO for Wales should have a duty to consult with RCPsych Wales as the professional membership body for psychiatrists when preparing guidance about the operation of the Act.

3. What are your views on whether the current proposals for guidance by the Chief Medical Officer provide sufficient safeguards to protect vulnerable individuals under the new assisted dying regulations?

We welcome that the Bill was amended at House of Commons Committee stage to provide that the persons consulted under section 37(2) must include persons with learning disabilities. We consider that section 37 could be further strengthened by mandating that a draft of the CMO for Wales' guidance must be laid before, and approved by, the Senedd. This would provide an additional safeguard and oversight to ensure the guidance is robust and fit for purpose. There should also be a duty to review the guidance, in line with the Bill's other monitoring and review provisions.

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Clause 39(1), (2), (5) and (6): Voluntary Assisted Dying Services: Wales

Clause 39 allows the Welsh Ministers to make regulations to support how voluntary assisted dying services work in practice in Wales. These regulations can be tailored to different situations (such as hospitals or care homes), and may include technical or transitional arrangements.

4. What are your views on the proposals to enable Welsh Ministers to provide, by regulations, for voluntary assisted dying services in Wales, determining how the services might be structured, managed and delivered?

We consider it constitutionally appropriate that Welsh Ministers should have regulation-making powers to provide for voluntary assisted dying/assisted suicide services in Wales.

5. How do you anticipate the forthcoming regulations by Welsh Ministers on voluntary assisted dying services will (if approved) impact current palliative care practices in Wales, considering the details of these regulations are still to be determined?

Although the provision of psychological care is a fundamental part of good palliative care, we know that adult patients' access to such support in UK hospices is limited. Until the provision of such care is improved, it is difficult to see how a person could be determined to be making a choice between options on AD/AS. We do wish to note that access to psychological care for people with palliative care needs is required whether or not AD/AS is legislated.

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Clause 45: Monitoring by Commissioner

Clause 45 requires the Voluntary Assisted Dying Commissioner (appointed by the Prime Minister) to monitor the operation of the Act, investigate and report to an appropriate national authority on any matter connected with the operation of the Act which the appropriate national authority refers to the Commissioner, and submit an annual report to each appropriate national authority on the operation of the Act.

6a. What are your views on the proposals to enable the Welsh Ministers to refer any matter connected to the operation of the Act to the Voluntary Assisted Dying Commissioner for investigation?

We are not opposed to this proposal.

On oversight specifically, we believe that, if an AD/AS service is introduced, standards of existing psychiatric practice must not be compromised. Any professional involved in assessments for AD/AS would need to be adequately experienced, trained, and independently overseen.

6b. What are your views on the proposals to require the Commissioner to consult with the Chief Medical Officer for Wales when preparing an annual report on the operation of the Act?

We are not opposed to this proposal.

6c. What are your views on the proposals to require the Welsh Ministers to publish the annual report submitted by the Voluntary Assisted Dying Commissioner, and prepare and publish a response to that report, which must both be laid before the Senedd?

We are not opposed to this proposal.

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Clause 47(4) – Provision of information in English and Welsh

Clause 47 requires any service, report, declaration or certificate of eligibility provided under the Act to a person seeking assistance to end their own life must be in the persons first language, if that language is English or Welsh and, if neither of those languages is their first language, must be in their preferred language of English or Welsh.

7a. What are your views on whether the Bill adequately ensures information and services are accessible in both English and Welsh? Specifically, what are your views on the proposals that require that any service, report, declaration or certificate of eligibility provided under the Act to a person seeking assistance to end their own life must be in the person's first language, if that language is English or Welsh. If English or Welsh is not their first language, they must be provided in whichever is their preferred language of English or Welsh?

We welcome that the Bill was amended at House of Commons Committee stage to provide for the provision of information in English *and* in Welsh. The failure to recognise the unique position and official status of the Welsh language in Wales was a clear omission in the Bill as introduced.

There are not enough psychiatrists to do what the Bill requires (see section 6 of annex 1 below). This is particularly pertinent when it comes to the significant shortage of Welsh-speaking psychiatrists and the need to ensure that the right of individuals in Wales to discuss the decision to end their life through the medium of Welsh can be upheld. Assessing capacity and identifying coercion in a person's first language also has significant implications for ensuring informed consent, safeguarding autonomy, and protecting against undue influence.

RCPsych Wales is currently undertaking modelling work to better understand the workforce implications of the TIA Bill in Wales.

We are committed to increasing opportunities for psychiatrists to develop their Welsh language skills and are working in partnership with the National Centre for Learning Welsh in that regard.

We have also called on the Welsh Government to develop a dedicated action plan for psychiatry in Wales to address shortages in the workforce, meet the rising and increasingly complex demand for mental health services, and the changing nature of the psychiatric profession in light of new treatments and legislative reforms, including the TIA Bill and the Mental Health Bill.

Increasing the provision of diagnostic and assessment services must also be a targeted focus of a national strategy by the Welsh Government.

7b. What are your views on whether the Bill adequately ensures information and services are accessible in both English and Welsh? Specifically, what are your views on the proposals that any regulations containing provision for the Welsh language must be approved by a resolution of the Senedd?

We agree with the proposal that any regulations containing provision for the Welsh language must be approved by a resolution of the Senedd.

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Clause 50(1), (2), (5) and (6) – Regulations

Clause 39 allows the Welsh Ministers to make regulations to support how voluntary assisted dying services work in practice. Clause 50 provides that such regulations must be approved by the Senedd before they can take effect.

8. What are your views on the proposed procedure for regulations made under the Act, and whether it provides the Senedd with an appropriate level of oversight?

We agree that the affirmative procedure is the appropriate procedure for regulations to be made under clause 39.

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Clause 54(6), (8) and (9) – Commencement

Clause 54 deals with the commencement of the Act.

9. What are your views on the proposal that the provisions of the Act (except sections 43, and 49 to 55) will come into force in Wales on the day(s) appointed by the Welsh Ministers by regulations?

We welcome that the Bill was amended at House of Commons Committee stage to provide Welsh Ministers with commencement powers in respect of Wales. This is a constitutionally appropriate development.

10. These regulations will have to be approved by the Senedd. What are your views on the appropriateness of this procedure?

We agree that the affirmative procedure is the appropriate procedure for regulations to be made under clause 54.

11. What are your views on the possible implications if this legislation were to be commenced at different times in Wales and England?

We welcome that the Bill was amended at House of Commons Committee stage to provide that the four-year commencement period would not apply to Wales. Most of the Bill's provisions will instead come into force in Wales only after draft regulations stipulating the start date(s) have been laid before, and approved by, the Senedd. This represents a mature and democratic acknowledgement of devolved decision-making, ensuring that the outcome of the Senedd's vote on the Legislative Consent Memorandum on the Bill can be properly respected.

That said, full and detailed consideration must be given to potential cross-border issues resulting from the legislation being commenced at different times, particularly in terms of professional and legal implications for the psychiatric workforce.

Annex 1: The Royal College of Psychiatrists' position on the Terminally Ill Adults (End of Life) Bill

Introduction

This annex reflects the position of the RCPsych on the TIA Bill for England and Wales. It does not represent a position more broadly on the practice of assisted dying/assisted suicide nor on proposals currently before legislatures in other jurisdictions.

We have arrived at the views expressed within this annex after extensive consideration by our assisted dying/assisted suicide working group, surveying and engaging with our members, and discussions with parliamentarians and colleagues in other jurisdictions.

On 13 May 2025, RCPsych announced that it cannot support the Terminally Ill Adults (End of Life) Bill for England and Wales in its current form.

Specifically, we hold the following nine views in relation to the Bill:

1. Terminal illness is a risk factor for suicide.
2. There should be a requirement for a holistic assessment of unmet need.
3. Assisted dying/assisted suicide is not a treatment.
4. The Mental Capacity Act does not provide a framework for assessing decisions about ending one's own life.
5. It is not clear what a psychiatrist's role on a panel would be.
6. There are not enough psychiatrists to do what the Bill requires.
7. Professionals must be able to conscientiously object to involvement in any part of the process.
8. Robust professional standards and oversight would need to be in place.
9. Physical effects of a mental disorder should not make a person eligible for assisted dying/assisted suicide.

These statements are elaborated on below.

1. Terminal illness is a risk factor for suicide.

A terminally ill person is more likely to be depressed. There is significant overlap between the terminally ill population and those who are suicidal – these are not population groups that can be neatly separated.

As the voice of psychiatry, and an organisation that has campaigned for decades to prevent people from dying by suicide, it is important that we directly acknowledge that the passing of this legislation would result in amendments to the Suicide Act. What, then, would this mean for suicide prevention efforts among the terminally ill population in England and Wales?

A duty of care is imposed on clinicians to protect the safety and wellbeing of their patients, including those who are at risk of self-harm or suicide, by the Mental Health Act ("MHA"), the Mental Capacity Act ("MCA") and the Human Rights Act. Should the Terminally Ill Adults (End of Life) ("TIA") Bill become law, it needs to set out clearly how and at what point a practitioner would be deemed to have discharged this duty under existing legislation and codes of practice, while also acting in accordance with this Bill.

Currently, both national suicide prevention strategies for England and Wales identify physical illness as a risk factor for suicide that warrants intervention. Pain from unresolved physical symptoms can make a person want to die, as can fear of physical pain or death. Depression, which is often missed, is also strongly associated with a wish to die. But if a terminally ill person's physical pain or associated fear of it is alleviated, or their depression found and treated, this wish to die often dissipates.

2. There should be a requirement for a holistic assessment of unmet need.

If a person has needs that are not being met, they are more likely to want to die. Is the person in intolerable pain? Do they have access to good palliative care, social care and mental health services close to their home or community and for as long as they need it? Are they living in substandard housing or facing financial hardship? Have they experienced a recent personal loss or bereavement? Are they mentally ill? Are they depressed? Do they feel lonely, socially isolated or like a burden? Do they have spiritual care needs? Many of these things, alone or together, can make a person's life feel unbearable.

The TIA Bill requires the coordinating doctor, independent doctor, and multidisciplinary panel to be satisfied that a person has the capacity to make the decision and a clear, settled and informed wish to end their own life, free from coercion. It does not, however, suggest or require that a biopsychosocial assessment of unmet need be carried out at any stage, nor that information is gathered from other professionals involved in a person's care nor from people in their personal life. This means that a person with remediable or treatable needs that may be influencing their wish to end their own life could still be deemed to be making a capacitous, free, clear, settled and informed choice free from coercion.

It is good clinical practice to carry out a comprehensive holistic assessment of a patient so that they can be supported to affect the outcome that they want, and which is in their best interests. By looking at biological, psychological and social elements of a person who wishes to die, there is an opportunity to identify remediable and treatable aspects of their situation or symptom experience.

3. Assisted dying/assisted suicide is not a treatment.

This Bill is about the decisional right to end one's own life in terminal illness via the self-administration of lethal medications which have been prescribed by a doctor. While it is clear that what is being assessed is a person's capacity to decide to end their own life, the TIA Bill does not specify whether assisted dying/assisted suicide ("AD/AS") is a treatment option.

This ambiguity has major implications in law and for the role of psychiatrists; where similar legislation has remained ambiguous on this point in other jurisdictions – such as in Victoria, Australia – codes of practice have relied on decision-making tools which were developed specifically for treatment decisions.

The Secretary of State for Health and Social Care and Welsh Ministers have legal duties to "promote a comprehensive health service designed to secure improvement in the physical and mental health" of the population and "in the prevention, diagnosis and treatment of mental and physical illness." Should these roles be responsible for an intervention which is:

- not a treatment but requires pharmacological intervention; and
- sought expressly for the purpose of ending a person's own life?

AD/AS is not an intervention that can be neatly categorised or indicated for within existing clinical systems or ethical concepts. It is not one which aims to improve a person's health. Its intended consequence is death. What is before people considering AD/AS is an existential choice about a life-ending intervention as opposed to a treatment option aiming to improve health. Should this Bill proceed, it should specify and be explicit 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 mental capacity to make decisions about their care or treatment, or other matters like finances. It provides professionals with a framework to assess a person's capacity to make decisions that are in their best interests around things like changing residence or getting surgery. The MCA does not provide a framework to determine a person's capacity to decide to end their own life.

Comparisons have been made between the TIA Bill's novel capacity test and assessments of capacity that are currently carried out under the MCA when a person wishes to withdraw from or refuse lifesustaining treatment. Throughout this process, we have observed philosophical arguments about acts versus omissions, but what is functionally important for the capacity test in this example is that a refusal involves choosing not to receive a treatment. There is a clear distinction between not keeping a terminally ill person alive and ensuring that they are as comfortable as possible at the end of their life versus the active administration of lethal medications.

Were this Bill to proceed, implications for the MCA would need to be considered – how would we assess the new kind of capacity framed in the TIA Bill? Implications for the MHA would also need to be considered – how would we protect and empower people with terminal illness to decide whether or not to end their own life, while at the same time detain those who are at risk of suicide so that they can be urgently treated? For coherence, legislative attention needs to be given to these three laws – the MCA, MHA and TIA Bill – together.

5. It is not clear what a psychiatrist's role on a panel would be.

This Bill proposes that psychiatrists be involved in two main ways: through assessments of mental capacity as part of routine psychiatric practice and in a safeguarding role on a panel. The role of a psychiatrist on the panel in the TIA Bill as drafted appears to be to review the decisions of the assessing doctors, rather than assess for mental disorder which impairs capacity or unmet mental health need; this does not align exclusively with the skills and expertise of the profession.

Psychiatrists have expertise in the diagnosis and treatment of mental disorders and the impact of those disorders on decision making. While psychiatrists do sometimes advise other health professionals in instances when they are unclear about a person's decision-making capacity, a psychiatrist's role and clinical expertise is predominantly in psychiatric interventions in the context of a person's care and treatment; capacity assessments for the purposes of the MHA; and in determining whether a person with a mental illness, intellectual disability or neurodevelopmental condition can consent to their treatment.

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 someone is experiencing something that is contributing to their wish to die that can be remedied or treated. It would also be important to ensure that the appropriate intervention to address an unmet need is available should an AD/AS service be introduced – simply identifying that there are remediable or treatable needs that may be influencing a person's wish to end their own life is not enough.

6. There are not enough psychiatrists to do what the Bill require.

We must look at what is being proposed within the context of rising demand for mental health services. There has been a significant rise in mental ill-health, driven by an increase in risk factors – poverty, housing and food insecurity. As things currently stand, mental health services simply do not have the resource required to meet a new range of demands.

Among the trusts and local health boards across England and Wales that responded to our most recent workforce census, almost 1 in 6 consultant psychiatrist posts were vacant or unfilled. Based on NHS targets to expand the

workforce, there is a shortfall of almost 700 consultant psychiatrists across England alone. We are pleased to see that the Bill now requires assessments to be undertaken, and information provided, in Welsh when that is a person's first or preferred language, but this too carries with it resource implications.

Expected reforms to the MHA will also require more of the consultant workforce. Its Second Opinion Appointed Doctor system is being expanded significantly, but it is already stretched and largely made up of retired psychiatrists. Is it expected that the panels that the TIA Bill would create would also draw on this workforce? Where will the extra consultant psychiatrists to fill these roles come from? What kind of experience will be needed?

Whether this Bill proceeds or not, the capacity of the psychiatric workforce in England and Wales needs to be expanded.

7. Professionals must be able to conscientiously object to involvement in any part of the process.

We are pleased to see that the Bill no longer requires medical professionals who do not wish to be involved to refer a person to another clinician. However, we note that, if asked about AD/AS by a patient, professionals are required to direct a person to where they can obtain information on how to have a preliminary discussion.

For some psychiatrists who wish to take no part in such a service, this would constitute being involved in the process. Although an equal proportion of psychiatrists who responded to our survey indicated opposition (45%) and support (45%) respectively for AD/AS for people with terminal illness, most respondents (58%) said that they would not be willing to participate as a medical professional. It is therefore important that all clinicians, including psychiatrists, are afforded the right to not take part in an AD/AS service for any reason, including those who conscientiously object on professional, moral, religious or spiritual grounds.

In cases where a person clearly does not meet the eligibility criteria, the TIA Bill does not set out the extent to which a psychiatrist would have to comply with a patient's wish to progress to a preliminary discussion. What would the requirement to provide information mean for a patient of a psychiatrist who clearly does not meet the eligibility criteria and whose primary reason for asking to end their own life is a mental disorder? Were this Bill to proceed, this point should be clarified within it.

A psychiatrist's ability to form and maintain a therapeutic relationship with a suicidal patient could be detrimentally impacted if they were required to provide information on an AD/AS service when asked in every single case.

8. Robust professional standards and oversight would need to be in place.

If an AD/AS service is introduced, standards of existing psychiatric practice must not be compromised. 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. Access to peer group dialogue would also be important.

If capacity assessments for AD/AS become part of normal psychiatric practice, it is likely that a small proportion of psychiatrists will actively opt to undertake most of such assessments. Like existing aspects of psychiatric practice, quality needs to be monitored and assured, and training built into the process. Particular consideration would need to be given to the values of the psychiatrist and the relationship between the clinician and the person being assessed to ensure it was free of bias and did not impact the outcome.

Few psychiatrists will already have the experience of the patient group that is required to fully understand their needs. Small numbers of psychiatrists work in hospices and palliative care; psychiatrists in hospitals work with people with life limiting illnesses, and old age psychiatrists with people in the final years of their life. Most psychiatrists do not work with this patient group. For autistic people or people with intellectual disabilities, a psychiatrist with further specialist experience would be required.

We learn and develop professional practice by scrutiny and peer review. Capacity assessments and panel decisions need to be recorded, in all cases regardless of outcome.

9. Physical effects of a mental disorder should not make a person eligible for assisted dying/assisted suicide.

A key feature of some mental disorders – such as eating disorders, dementia, and alcohol and substance dependence – are physical characteristics and symptoms. While the Bill states that a person is not considered terminally ill only because of a mental disorder, it is silent on how the eligibility criteria are to be applied to people who are experiencing the physical effects of such conditions.

Under this Bill, a person could be deemed eligible based on severe physical complications of a mental disorder which would result in death if left untreated. Malnutrition caused by anorexia nervosa, for example, has been deemed as a terminal illness under similar pieces of legislation in other jurisdictions. However, in England and Wales, eating disorders can currently be treated under existing mental health legislation, even when an individual would rather die than gain weight; such thoughts, while genuine, are often a symptom of the illness and frequently diminish with treatment.

Physical consequences of mental disorder can also impair capacity in ways that are difficult to detect. Starvation, for example, can cause memory problems and significantly impact the way a person weighs information.

If the TIA Bill were to proceed, it would be essential to include provision within it for excluding the physical effects of mental disorder as the basis for eligibility. To not do so would risk the erosion of trust in psychiatric care and the normalisation of therapeutic nihilism in the face of severe illness.