

## **Safeguards Briefing: Assisted Dying for Terminally Ill Adults (Scotland) Bill**

The Scottish Association of Social Work (SASW), Association of Palliative Care Social Workers (APCSW) and Social Work Scotland (SWS) have prepared this briefing in advance of the Stage 3 debate.

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### **Who we are**

SASW is the largest membership association for social workers in Scotland, part of BASW UK. APCSW is a membership organisation and the professional association for social workers working predominantly with people living with palliative care illness in the UK. SWS are a membership organisation, supporting the professional leadership and management of social work in Scotland.

We have made sustained efforts at each stage of this Bill's progress, through various forums and amendments, to introduce fundamental safeguards. To date, these concerns have not led to sufficient improvements in safeguarding. This paper sets out the safeguarding concerns we have regarding the proposed Assisted Dying for Terminally Ill Adults (Scotland) Bill. Our concerns relate specifically to the proposed legislation as currently drafted and do not take a position on assisted dying in principle.

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### **Our main point**

The Bill, as it stands before parliament at Stage 3, is unsafe for the people of Scotland.

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### **What needs to change at Stage 3**

If the amendments supported below are not passed, the Bill will not reach a minimum safe threshold from a social work perspective. Other professions and organisations may have their own views on the safety and practicality of the Bill. As representatives of the social work profession, our priority is the safety and human rights of those who may want to access the services this Bill will create.

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### **Essential safety standards in existing legislation**

In order to raise safeguards to the essential minimum, this Bill must acknowledge and incorporate the statutory safeguards already written into the fabric of Scottish health and social care. Established successive law enshrines layers of protection for people who are most vulnerable to or experiencing harm, abuse, mental ill health, or who lack capacity. The Adults with Incapacity (Scotland) Act 2000 (herein known as the AWI Act) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (herein known as the Mental Health Act) together provide the main legal framework in Scotland for safeguarding adults who lack capacity or have a mental health condition. The AWI Act

establishes a clear legal standard for the assessment of capacity and, where it is found to be lacking, allows for the appointment of guardians, attorneys, or intervention orders to make decisions on a person's behalf in their best interests, while the Mental Health Act provides powers for compulsory care and treatment where necessary. Together, with the Adult Support and Protection (Scotland) Act 2007, these serve as essential safeguards against harm, exploitation and coercion, ensuring that vulnerable adults are protected not only from others who may wish to cause them harm, but also from decisions driven by institutional convenience rather than their own rights, welfare and dignity. These are not new standards; they are established law, and this Bill cannot responsibly ignore them.

The importance of multidisciplinary involvement in assessments of this nature is not only a matter of good practice, but also increasingly recognised as essential by those examining equivalent legislation elsewhere. The Jersey Review Panel, in its recent examination of assisted dying safeguards, concluded that assessments must draw on a broader range of professional expertise than medical training alone can provide, and that clinicians, while central to the process, may not always have specialist knowledge of coercive control, safeguarding dynamics, or complex capacity assessment. This is precisely the gap this Bill fails to address.

Amendments at Stage 2, which made referral to social services at the discretion of the medical practitioner, recognised the need for such multidisciplinary working. However, by leaving this vital safeguard at the discretion of the coordinating medical practitioner, they failed to recognise that it is not within the professional competence of a medical practitioner to safely assess whether this input is needed.

Further, local authorities hold statutory duties and maintain records relevant to the person's circumstances. Without inquiry, this information will not be available to the medical practitioner. Such a duty is required for decisions about the person's capacity and vulnerability to coercion to be properly informed. This should include information about any records of reported concerns, capacity and specialist mental health assessments, inquiries and safeguards existing for the person. Ensuring that medical practitioners have a duty to consult with the Local Authority is the only means of establishing that the person is not subject to existing statutory processes that have bearing on their decision.

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### **Coercion, social risk and multi-disciplinary assessment**

The risks of coercion, undue influence, financial abuse, domestic abuse and internalised pressure are not theoretical. Our members work daily with people

experiencing exactly these circumstances — including situations where individuals have been conditioned over time to minimise their own needs or to protect family assets at personal cost. These pressures can be invisible to a medical practitioner conducting a clinical assessment, they can also be invisible to the person experiencing them.

Coercion does not only arise from individuals it can be systemic. Societal and institutional pressures, including pervasive narratives around being a burden, the cost of care, or the emotional and financial toll on families, can shape a person's decision in ways that are profound and deeply difficult to detect. The Bill does not define what is meant by coercion. A clear and shared understanding of what coercion looks like in practice, including its societal, institutional and internalised forms, is needed to form a basis for its identification. This will need to be resolved in guidance where clear definitions of coercion, which can evolve as our understanding grows, will be essential.

These concerns are borne out by the Jersey Review Panel's findings (19/02/2026). Coercion is multifaceted, often subtle, and requires safeguards that address both external and internal pressures. Evidence consistently demonstrates that coercion rarely presents as overt force, instead, it may arise through emotional dependence, family dynamics, perceived burden, financial pressures, or relational influence. Certain groups face heightened vulnerability, including individuals with mental health conditions, neurodivergence, sensory impairments, or complex social environments, reinforcing the need for specialist training, careful capacity assessment, and contributions from practitioners with expertise in safeguarding, mental health and social care. Crucially, effective safeguarding against coercion relies on multidisciplinary assessment, not medical evaluation alone. Clinicians cannot be expected to identify coercion fully without access to Local Authority and mental health records, and the expertise of safeguarding professionals, mental capacity specialists and social workers.

Medical practitioners are not trained to identify social risk and coercion at this level, nor to know when specialist input is required. A solution to this can be applied through guidance to ensure appropriate assessment takes place where concerns are identified. This would include a social work assessment or psychosocial background report, depending on the risks raised, prepared by an appropriately qualified professional prior to the request being progressed.

The coordinating medical practitioner cannot be expected to make a safe and informed decision in the absence of the full context. A medical practitioner equipped with this fuller picture is better placed to make a sound, defensible decision. This approach is

supported by the additional layers of scrutiny and rigour recommended by the Jersey Review Panel and applied in equivalent legislation in England and Wales. There is no principled reason the Scottish Bill should offer less protection to the people it serves.

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### **A separate service**

We believe it would be advantageous for a separate assisted dying service to be created and urge you to support the amendment below, which would create one. If created, this service should sit as a delegated duty within integration authorities (HSCPs), creating stronger ties and links to palliative care and social services.

Adding assisted dying to existing primary care settings will add strain to an already stretched system. Bringing it closer to palliative care and social services within integration would make communication and multidisciplinary working easier.

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### **Conclusion**

We are not opposed to assisted dying in principle. We are opposed to this Bill as drafted. The concerns set out in this briefing are not aspirational; they reflect existing Scots law, established safe practice, the daily reality of our members' work with Scotland's most vulnerable people, and the emerging evidence base from elsewhere in the British Isles. They represent the fundamental minimum required to make this legislation safe enough to pass into law.

We have raised these concerns at every stage of this Bill's progress but have not been heard. We are raising them again now because the consequences of failing to act are irreversible for the individuals this Bill will affect, and for the parliament that passes it.

The responsibility for the safe introduction of this legislation rests with ministers and with every MSP who votes on it. Scotland's most vulnerable people cannot be an afterthought in a Bill designed to serve them. We urge parliament to support the amendments set out in this briefing, and if they fail to pass this Bill should not become law.

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### **Amendments to support**

We urge you to support *Amendment 250* that will create a separate assisted dying service.

We urge you to support *Amendment 171* that will require medical practitioners to consult with Local Authorities about existing measures and to engage multidisciplinary expertise in the assessment process. Without mitigating irreversible harm through this essential safety standard, this Bill should not pass.



*Consequential amendments 306 and 309 should be passed with these.*

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**Further information**

Association of Palliative Care Social Workers - [Association of Palliative Care Social Workers](#)

Scottish Association of Social Work - [Scottish Association of Social Work | BASW](#)

Social Work Scotland - [Social Work Scotland - Leading the Profession](#)

Jersey Review Panel report: 19 February 2026 - [S-R-4-2026-Review-of-Assisted-Dying-Legislation.pdf](#)