

Assisted dying (assisted suicide): issues for the counselling professions in England and Wales

Good Practice in Action 058 Legal Resource

Assisted dying (assisted suicide): issues for the counselling professions in England and Wales

Good Practice in Action 058 Legal Resource

Updated August 2024

Copyright information

Good Practice in Action 058 Legal Resource: *Assisted dying (assisted suicide): issues for the counselling professions in England and Wales* is published by the British Association for Counselling and Psychotherapy, BACP House, 15 St John's Business Park, Lutterworth, Leicestershire, LE17 4HB.

T: 01455 883300 **E:** bacp@bacp.co.uk **www.bacp.co.uk**

BACP is the largest professional organisation for counselling and psychotherapy in the UK, is a company limited by guarantee 2175320 in England and Wales, and a registered charity, 298361.

Copyright © 2016-2024 British Association for Counselling and Psychotherapy.

BACP and the BACP logo are registered trademarks of BACP.

Permission is granted to reproduce for personal and educational use only. Commercial copying, hiring and lending are prohibited.

Design by Steers McGillan Eves.

Contents

Quick Guide – Where to find information	4
Context	5
Using the Legal Resources	5
Introduction	6
1 Suicide	7
2 Assisted dying (assisted suicide) – is this always a criminal offence?	8
2.1 What is assisted dying (assisted suicide)?	8
3 Case law relating to encouraging or assisting suicide	11
4 The Director of Public Prosecutions (DPP) Policy for prosecutors in respect of cases of encouraging or assisting suicide (MoJ 2010, updated 2014)	14
5 Duty of care in relation to clients considering assisted suicide	21
6 Assessment and referral of clients considering assisted suicide	22
7 Confidentiality, disclosures and consent	24
7.1 Mental capacity (adults)	25
7.2 Mental capacity (children and young people under the age of 18)	26
8 Possible new law in the making	28

About the author	30
Cases	30
Statutes	31
Statutory instruments	32
Conventions and protocols	32
References and further reading	33
Useful contacts and resources	36

Quick Guide – Where to find information

Question	Part
Is suicide a criminal offence?	1
What is assisted dying (assisted suicide)?	2
Is assisted dying (assisted suicide) an offence?	2
Guidance on prosecution of assisted suicide offences	4
Professionals' duty of care to clients considering assisted dying (assisted suicide)	5
Assessment and referral	6
Confidentiality for adults	7.1
Confidentiality for children and young people	7.2
New law on assisted dying in the making	8
Where to find help and information	Useful contacts

Context

This resource is one of a suite prepared by BACP to enable members to engage with the current BACP *Ethical Framework for the Counselling Professions* (BACP 2018) (the *Ethical Framework*) in respect of the law relating to assisted death and suicide in England and Wales. In Northern Ireland, the law on assisted suicide is similar to the English law. The Director of Public Prosecutions in Northern Ireland has issued a similar Policy to that operating in England and Wales. The law in Scotland is different, and for this reason, BACP may be publishing an additional resource on the law on assisted suicide in relation to the law in Scotland.

Using the Legal Resources

The membership agreement with BACP establishes a contractual commitment by members to abide by the *Ethical Framework for the Counselling Professions*, which includes a responsibility for members to keep the skills and knowledge relevant to their work up to date.

The Legal Resources cannot constitute legal advice or guidance in specific cases, nor are they sufficient on their own to resolve legal issues arising in practice. The Legal Resources do not give a full statement of the law. They are solely intended to support good practice by offering general information on legal principles and policy applicable at the time of writing. The Legal Resources are intended for information purposes only and are not a substitute for professional advice. BACP and the author accept no responsibility for and accepts no liability as a result of any person acting or refraining from acting on the basis of the Legal Resources.

Practice issues and dilemmas are often complex, and may vary depending on clients, particular models of working, the context of the work and the therapeutic interventions provided. We therefore strongly recommend consulting your supervisor, and also, wherever necessary, a suitably qualified practitioner or lawyer.

Some professional insurers will provide legal advice as part of their service.

BACP and the author make no representation or warranty as to the completeness or accuracy of the information contained in the Legal Resources. References in this resource were up to date at the time of writing but there may be changes in particular to the law, government departments, government policies and guidance, websites and web addresses. Organisations and agencies may also change their practice or policies, so please be alert for any changes that may affect your therapy practice.

In this resource, the words 'counselling,' 'therapist' and 'therapy' are used to refer specifically to counselling and psychotherapy.

The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of the counselling professions, including counselling, psychotherapy, coaching, professional mentoring and pastoral care.

Introduction

This resource refers to law in relation to assisted death as it applies to the provision of counselling and psychotherapy in England and Wales. Although some of these legal provisions may apply to other jurisdictions, different or additional statutory provisions and regulations are made for other regions in the UK.

Assisted dying, otherwise referred to as assisted suicide, is never an easy thing to think about, and it is a difficult subject for law making. Attempts have been made in the past to create new law on assisted dying, but so far, none have been made into statute. However, in 2021, the *Assisted Dying Bill* was introduced in the House of Lords as a private member's bill, with the intention to 'Enable adults who are terminally ill to be provided at their request with specified assistance to end their own life; and for connected purposes.' and that Bill reached its second reading, but progressed no further. Now, with the new Labour Government, the *Assisted Dying For Terminally Ill Adults Bill* was started in the House of Lords, and if successful, it will significantly change the current law. Should the Bill attain the status of statute law, this resource will be updated to reflect those changes. Please see Part 8 for information about the new Bill and proposed changes in the law.

Assisted dying affects not only the individual contemplating their own death, but also their friends, family, work colleagues and social groups. The manner of a death may also have a strong impact on the health and welfare of others.

Contemplation of and preparation for suicide, when presented as an issue in the course of therapy, is likely to generate a variety of challenging issues and emotions, and for this reason, our professional ethics must have a certain level of flexibility to cover all the wide variety of situations that may present themselves. See GPIA 057: *Suicide; Counselling Skills in Action 4th Edition* (Stafford and Bond 2021); *Working with Suicidal Clients* (Reeves 2010); *Working with Risk in Counselling and Psychotherapy* (Reeves 2015) and *Standards and Ethics for Counselling in Action 5th edition* (Reeves and Bond 2021) for practice information relating to working with suicidal clients.

In relation to any potential prosecution for the criminal offence of illegally assisting a person to die, the police and lawyers will consider the question of motivation – has the person freely chosen an assisted death – for example – are they choosing this way to die with the active encouragement, or even direct pressure from others, and are those others likely to benefit from that assisted death? Clients need to be free to talk over these difficult issues with their counselling practitioner, but at the same time that practitioner needs to be aware of the legal and ethical standards to be applied.

Therapists are required under the current *Ethical Framework*, (BACP 2018) to work within the law, and so a knowledge of the law as it applies to suicide and to what may be a complex therapeutic dilemma is helpful, particularly in considering our duty of care, risk assessment, consent and referral issues.

The Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide (MoJ 2010, updated 2014) refers to the person who has died or attempted to die as 'the victim'. Some counselling practitioners may dislike this terminology, but it is used in this resource where it reflects the words of the guidance.

1 Suicide

Suicide is defined here as the act of taking one's own life.

Under section 1 of the Suicide Act 1961 it is not a criminal offence to carry out suicide. It is, however, a criminal offence under section 2 of the Suicide Act 1961 to encourage or assist a person to carry out suicide or to attempt to carry out suicide, (see GPiA 057 Legal Resource: *Suicide: issues for the counselling professions in England and Wales*).

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) features the most current text updates based on scientific literature with contributions from more than 200 subject matter experts. The revised version includes a new diagnosis, modifications to the criteria sets for more than 70 disorders, addition of *International Classification of Diseases, Eleventh Revision, Clinical Modification* (ICD-11-CM), symptom codes for suicidal behaviour and non-suicidal self-injury, and updates to descriptive text for most disorders based on extensive review of the literature. For details and links, see the website www.psychiatry.org/psychiatrists/practice/dsm.

2 Assisted dying (assisted suicide) – is this always a criminal offence?

2.1 What is assisted dying (assisted suicide)?

The terms 'assisted dying' and 'assisted suicide' denote the same thing. Reference is also made to 'assisted death'. The Ministry of Justice and some courts use the term 'assisted suicide', while the 2021 Bill before the House of Lords was entitled 'Assisted Dying.' For the sake of brevity, this resource refers throughout simply to 'assisted dying' or 'assisted death', intending these to be inclusive terms, and in line with current parliamentary and court language and policies.

Assisted dying (or assisted suicide) is defined in this resource as the process of dying, which is directly caused, assisted or facilitated in any way by the actions of another person, carried out at the express wish and with the full consent of the person who wishes to be assisted to die. In cases where a person is at the end of their life, the British Medical Association has provided physicians with ethical guidance: see BMA *Physician-Assisted Dying: Ethical Position* at: www.bma.org.uk.

In this resource, whenever the term assisted dying is used, except where otherwise stated, it refers to actions which are carried out at the *person's express wish and with their consent, to assist them to end their own life*, because this is their expressed wish. In this resource, unless otherwise stated, the term therefore does **not** include manslaughter, or murder, or involuntary euthanasia – see below for legal definitions. The term also does not include the lawful withdrawal of life support treatment.

Helping another person to die could in many circumstances amount to the criminal offence of murder, manslaughter, or illegally assisting suicide, even if they do so on the basis that they believe that they are complying with the wishes of the other person concerned.

Murder

Murder represents the most serious form of homicide, and it is a common law offence in England and Wales, although some of its ingredients have been altered by legislation, most significantly by the Homicide Act 1957. The offence of murder involves the perpetrator killing a person when intending either to kill or to inflict grievous bodily harm. A conviction for murder carries a mandatory life sentence.

Manslaughter

Manslaughter is also a common law offence with statutory amendments, again most notably in the Homicide Act 1957.

Manslaughter can be committed in one of three ways:

- a.** killing with intent to murder but where there is a partial defence such as loss of control or diminished responsibility;
- b.** as a result of conduct that was grossly negligent given the risk of death, and did kill; or
- c.** as a result of conduct taking the form of an unlawful act involving a danger of some harm, that resulted in death.

The offence of voluntary (as opposed to involuntary) manslaughter is, in effect, murder in circumstances where the perpetrator is able to raise certain specified grounds of mitigation, including diminished responsibility and loss of control (all of which are subject to certain legal requirements). Manslaughter carries a maximum sentence of life imprisonment, and there is no minimum sentence.

Mercy killing

'Mercy killing' is a colloquial term which means killing another person for motives which appear, at least to the perpetrator, to be well-intentioned, namely for the benefit of that person, very often at that person's request.

Nonetheless, mercy killing involves the perpetrator intentionally killing another person, and therefore, even where that person wished to die, or the killing was purely out of compassion and love, the current state of the law is that the killing will amount to murder or (if one or more of the mitigating circumstances are present) manslaughter – see per Lord Judge CJ in *R v Inglis* [2011] 1 WLR 1110, para 37. As Lord Browne-Wilkinson said in *Airedale NHS Trust v Bland* [1993] AC 789, 885, "the doing of a positive act with the intention of ending life is and remains murder".

Involuntary euthanasia

Involuntary euthanasia is a term sometimes used to define the act of causing or helping a terminally ill person to die, but done without their knowledge or consent, or the consent of any other person authorised to do so on their behalf. This may happen either because they want to live or because they or those with the power to give consent were not consulted or asked to express their wishes. This is likely to fall within the definition of the criminal acts of murder or manslaughter.

Note: In contrast, some actions, which cause the ending of a life, or allow a person to die, may be carried out with appropriate lawful consent, or legally authorised by a court, for example where relatives give consent, or a court authorises the withdrawal of certain treatment or life support for a terminally ill patient.

Assisting suicide

Under section 2 of the Suicide Act 1961, it is an offence to do an act capable of encouraging or assisting the suicide or attempted suicide of another person and which is intended to encourage or assist the suicide or attempted suicide of that person. The person does not have to carry out the criminal act personally. An act arranged to be carried out by another person may also constitute the offence.

Such acts might for example include verbal or physical threats or encouragement, and/or the provision of the physical means of suicide, with instructions and/or encouragement to use it. In relation to these provisions of the Suicide Act 1961, it does not matter whether the suicide or attempted suicide then actually occurs.

The criminal offence of assisting suicide is triable on indictment, and the Director of Public Prosecutions (DPP) must consent to the prosecution. On conviction, the penalty for this offence is a maximum sentence of up to 14 years' imprisonment.

There are circumstances in which a person wishes to carry out suicide, but is physically incapable of doing so, and seeks the assistance of another person to help them carry out their wishes. Any person helping in this way therefore runs the risk of prosecution for a criminal offence, and it falls to the DPP to decide whether it is in the public interest to prosecute. Each case is considered by the DPP and decided on its merits.

The police and the Crown Prosecution Service (CPS) have to refer to criteria specified in the Director of Public Prosecutions Guidance *The Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (MOJ 2010, updated 2014), to consider whether a prosecution is lawful, and necessary in the public interest.

The Crown Prosecution Service (CPS) publishes a link to the DPP Policy on their website at www.cps.gov.uk/publication/assisted-suicide and the website also reports that –

'From 1 April 2009 up to 31 March 2022, there have been 174 cases referred to the CPS by the police that have been recorded as assisted suicide. Of these 174 cases, 115 were not proceeded with by the CPS and 33 cases were withdrawn by the police.

There are currently eight ongoing cases. Four cases of encouraging or assisting suicide have been successfully prosecuted. One case of assisted suicide was charged and acquitted after trial in May 2015, and eight cases were referred onwards for prosecution for homicide or other serious crime.'

There have been a number of cases before the courts where the way in which the law operates has been challenged and these principles have been tested, particularly in those cases where the expressed wish of the victim was clearly to die.

Some people who are terminally ill have challenged the law, seeking permission in advance for them to have an assisted death. In these cases, pleas were made for either a change in the law, or at the very least, a clear policy from the DPP about whether prosecution would follow an alleged offence of assisting the suicide of another person. These cases and the resulting Director of Public Prosecutions Guidance *The Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* issued in February 2010, and updated in October 2014, are discussed in part 3.

3 Case law relating to encouraging or assisting suicide

In part 2, we have explored the law providing that doing an act that ends the life of another person may amount to the criminal offence of murder or manslaughter, and that assisting suicide is also a criminal offence. This applies, even when the person carrying out the act believes they are acting in accordance with the wishes of the person who dies. Attempts to carry out such acts may also constitute an offence.

In the case of *R (on the application of Purdy) v Director of Public Prosecutions* reported at [2009] UKHL45, which came before the House of Lords (now the Supreme Court), the claimant, Debbie Purdy, who suffered from primary progressive multiple sclerosis, wanted to be able to travel to Dignitas in Switzerland with her husband to end her life, when they both felt that the time was right to do so. As the law stands, her husband might risk prosecution in helping her to die in this way. Debbie Purdy wanted to know what factors the Director of Public Prosecutions (DPP) would take into consideration in deciding whether a prosecution should be brought under section 2 of the Suicide Act 1961 if her husband helped her to travel to a country, such as Switzerland, where assisted suicide is currently lawful. She proposed that the prohibition of encouraging or assisting suicide in section 2(1) of the Suicide Act 1961 constituted an interference with her right to respect for her private life in article 8(1) of the Convention for the Protection of Human Rights and Fundamental Freedoms that was not “in accordance with the law” as required by article 8(2) in the absence of an offence-specific policy by the Director setting out the factors that would be taken into account under s. 2(4). The term ‘assisting’ suicide is interpreted as aiding, abetting, counselling or procuring the suicide or attempt to carry out suicide.

Having considered earlier decisions, the House of Lords ruled that the law was insufficiently accessible and precise to enable a person affected by it to understand its scope and foresee the consequences of his actions so that he could regulate his conduct.

The case of Purdy (and the earlier case of Pretty) did not change the law, but as a result, the DPP was impelled to consider its policy regarding prosecutions in relation to assisted suicide.

A court case was brought before the European Court of Human Rights (ECHR) in 2014 by Paul Lamb and Jane Nicklinson, the widow of Tony Nicklinson, and 'Martin' (so described to protect his privacy). Paul Lamb and Martin both suffer severe physical incapacity, and wanted the court to rule on the right of disabled people to be helped to die with dignity. The widow of Tony Nicklinson supported their application and appealed in her own right. Her husband Tony had applied to the High Court for a declaration of lawfulness to allow a doctor to kill him or to assist him in terminating his own life, and a declaration that the current state of the law was incompatible with Article 8 of the European Convention on Human Rights.

The High Court expressed great sympathy and respect, but refused him both forms of relief, and so Tony Nicklinson took the only other course that he felt was open to him and refused all forms of nutrition, fluids and medical treatment, and died of pneumonia on 22 August, 2012. The Court of Appeal and the House of Lords both subsequently rejected the application. The three appellants then appealed to the ECHR on the basis that the prohibition on assisted suicide in the Suicide Act 1961 was against the European Convention on Human Rights.

The ECHR court report states:

9. 'Martin suffered a brainstem stroke in August 2008, when he was 43. He is almost completely unable to move and can only communicate thorough slow hand movements and via an eye blink computer. His condition is incurable, and, despite being devotedly looked after by his wife and carers, his evidence is that he wishes to end his life, which he regards as undignified, distressing and intolerable, as soon as possible.

10. Apart from self-starvation, Martin's only way of achieving this is by travelling to Zurich in Switzerland to make use of the Dignitas service, which, lawfully under Swiss law, enables people who wish to die to do so. However, he first needs (i) to find out about this service, (ii) to join Dignitas, (iii) to obtain his medical records, (iv) to send Dignitas money, and (v) to have someone accompany him to Zurich. For understandable reasons, his wife does not want to be involved, and he does not want to involve any other member of his family, in this project. So, as he says, he needs assistance from one of his carers or from an organisation such as Friends At The End'. (Paras 9–10).

The ECHR 2014 judgment (Para 18) comments on the case of Bland where it was held to be lawful for doctors to discontinue treatment for a patient in what was then called 'a persistent vegetative state'. 'Nonetheless, a doctor commits no offence when treating a patient in a way which hastens death, if the purpose of the treatment is to relieve pain and suffering (the so-called "double effect") – see per Lord Goff of Chieveley in Bland at p867.

The House of Lords in that case decided that no offence was involved in refusing or withdrawing medical treatment or assistance, ultimately because this involved an omission rather than a positive act. While Lord Goff, Lord Browne-Wilkinson and Lord Mustill were all concerned about the artificiality of such a sharp legal distinction between acts and omissions in this context, they also saw the need for a line to be drawn, and the need for the law in this sensitive area to be clear – see at pp865, 885 and 887 respectively.’

The ECHR decided that each member state should have the right to decide whether its law on assisted suicide infringes Article 8 of the European Convention on Human Rights, and so would not interfere with the ruling of the Supreme Court in the UK.

More recently, other similar cases have been brought before the courts, each one involving people with serious and/or terminal illness, and to date, all have met with similar judgments.

Noel Conway, a retired lecturer, paralysed from the neck downwards by motor neurone disease applied to the Supreme Court in November 2018 to challenge the legal ban on assisted dying.

The Supreme Court (Lady Hale, Lord Kerr and Lord Reed) acknowledged that the issue was of ‘transcendent public importance’ but continued to uphold the current statute law. It therefore seems that to change the law, new statutory legislation would be required

Cases on lawful withdrawal of life support treatment

More recently, there have been several court cases concerning the withdrawal of life support from patients with incurable and terminal illness. There were two cases involving very young children, Charlie Gard, and Alfie Evans reported in the newspapers and in court reports, in which the court issued a declaration of lawfulness, effectively authorising medical staff to withdraw life support in what was judged by the court and medical professionals to be the best interests of the child. Until recently, these decisions had to be made by application to the Court of Protection.

On 30 July 2018, in the case of *An NHS Trust and others (Respondents) v Y (by his litigation friend, the Official Solicitor) and another (Appellants)*, [2018] UKSC 46; the UK Supreme Court issued a ruling that, if it is in the patient’s best interests, life support may be withdrawn by medical staff in cases where the patient has been in a persistent vegetative state for a long time and is medically judged to be unlikely to recover. Reference must be made to professional medical guidance, and to the Mental Capacity Act 2005 Code of Practice (issued under section 42 of the Mental Capacity Act 2005), Chapter 5 of which refers to actions in the patient’s best interests, and in particular, paras 5.31-5.33; 6.18-6.19. Chapter 8 deals with the role of the Court of Protection. The decision must be made, with certain safeguards, by doctors in conjunction with the patient’s family and legal attorneys.

The Supreme Court ruling includes this statement:

'If the provisions of the MCA 2005 are followed and the relevant guidance observed, and if there is agreement upon what is in the best interests of the patient, the patient may be treated in accordance with that agreement without application to the court. I would therefore dismiss the appeal.

In so doing, however, I would emphasise that, although application to court is not necessary in every case, there will undoubtedly be cases in which an application will be required (or desirable) because of the particular circumstances that appertain, and there should be no reticence about involving the court in such cases.'

Please note, however, that these cases are not legally regarded as 'assisted suicide', but are classed as the 'withdrawal of life support treatment.'

4 The Director of Public Prosecutions (DPP) Policy for prosecutors in respect of cases of encouraging or assisting suicide (MoJ 2010, updated 2014)

The application of the law, and the decision on whether to prosecute an alleged criminal offence or not is subject to prosecution policy. Prosecution policy is made by the Crown Prosecution Service in England and Wales, or the Procurator Fiscal Service in Scotland. In making a prosecution decision, with the alleged offence of assisting or encouraging suicide as with any other, the Crown Prosecution Service and the Director of Public Prosecutions apply two tests. One is an evidential test: is there evidence that the offence has been committed? Secondly, there is a public interest test: does it serve the public interest to pursue a prosecution?' The decision as to whether prosecution is justified in the public interest, is one which has required some legal clarification. The result of Purdy and other cases discussed in part 3, was that on 25 February 2010 the Director of Public Prosecutions launched the *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide*, and it is intended to assist prosecutors in making this decision. It is available at: www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide. The policy was updated in 2014 (MoJ 2014). The policy provides guidance to prosecutors on the public interest factors to take into account in reaching decisions in cases of encouraging or assisting suicide.

The wording of the DPP's 2014 policy 'encouraging or assisting suicide' clearly demonstrates a moral distinction between: (a) actions causing the death of another person (which may be against the victim's wishes) i.e. murder or manslaughter; and (b) the different actions and motivation of 'encouraging or assisting suicide' (which may be carrying out the victim's expressed wish), in relation to which the DPP will operate the policy (MoJ 2014) to assess whether (or not) it is in the public interest to prosecute those actions as a criminal offence. The policy states specifically in Para 6 that it does not change the statute law.

There has been criticism that the policy still leaves some level of uncertainty about whether a well-meaning relative or friend could be prosecuted for actions that they say were motivated by compassion, and as the law stands at present, they would still run the risk of prosecution, and would have to wait for the DPP to operate the policy before they know whether or not they will be prosecuted.

As a result, there have been continued attempts to change the offence embodied in the statute law, to allow assisted death to become legal under statute. So far these attempts to change the statute law have not succeeded. As already mentioned in section 3, a recent challenge to the law on assisted suicide in section 2 of the Suicide Act 1961 was made in the European Court of Human Rights (ECHR) in 2015 by Jane Nicklinson on behalf of her husband Tony, and by Paul Lamb, because these men wished to end their lives, but could not do so without assistance. Their claims were dismissed by the ECHR on the basis that it was for the national Parliament in the UK to decide cases of such a sensitive issue.

The DPP has tried to create as much certainty as possible without changing statute law ... saying that 'the public can have full confidence in the policy the CPS will follow in deciding whether or not to prosecute cases of assisted suicide.' The Director published the policy after taking account of almost 5,000 responses received as part of what is believed to be the most extensive snapshot of public opinion on assisted suicide since the Suicide Act 1961 was introduced.

The Director said: "The policy is now more focused on the motivation of the suspect rather than the characteristics of the victim. The policy does not change the law on assisted suicide. It does not open the door for euthanasia.

It does not override the will of Parliament. What it does is to provide a clear framework for prosecutors to decide which cases should proceed to court and which should not".

The DPP office added "Assessing whether a case should go to court is not simply a question of adding up the public interest factors for and against prosecution and seeing which has the greater number. It is not a tick box exercise. Each case has to be considered on its own facts and merits."

Below are extracts from the Ministry of Justice *Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide* (MoJ 2010, updated 2014). For the full text see www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide:

1. A person commits an offence under section 2 of the Suicide Act 1961 if he or she does an act capable of encouraging or assisting the suicide or attempted suicide of another person, and that act was intended to encourage or assist suicide or an attempt at suicide. This offence is referred to in this policy as 'encouraging or assisting suicide'. The consent of the Director of Public Prosecutions (DPP) is required before an individual may be prosecuted.

2. Committing or attempting to commit suicide is not, however, of itself, a criminal offence.

6. This policy does not in any way 'decriminalise' the offence of encouraging or assisting suicide. Nothing in this policy can be taken to amount to an assurance that a person will be immune from prosecution if he or she does an act that encourages or assists the suicide or the attempted suicide of another person.

7. For the purposes of this policy, the term 'victim' is used to describe the person who commits or attempts to commit suicide.

Not everyone may agree that this is an appropriate description but, in the context of the criminal law, it is the most suitable term to use.

13. Prosecutors must apply the Full Code Test as set out in the Code for Crown Prosecutors in cases of encouraging or assisting suicide.

The Full Code Test has two stages: (i) the evidential stage; and (ii) the public interest stage. The evidential stage must be considered before the public interest stage. A case which does not pass the evidential stage must not proceed, no matter how serious or sensitive it may be. Where there is sufficient evidence to justify a prosecution, prosecutors must go on to consider whether a prosecution is required in the public interest.

14. The DPP will only consent to a prosecution for an offence of encouraging or assisting suicide in a case where the Full Code Test is met.

(Referring to cases occurring after 1 February 2010),

17. In these cases, for the evidential stage of the Full Code Test to be satisfied, the prosecution must prove that:

- the suspect did an act capable of encouraging or assisting the suicide or attempted suicide of another person; and
- the suspect's act was intended to encourage or assist suicide or an attempt at suicide.

In the policy there follows detail about the actions which constitute murder or manslaughter, and the public interest factors tending in favour of prosecution (paras 43-44), and against prosecution (paras 45-48).

Public interest factors tending in favour of prosecution

43. A prosecution is more likely to be required if:

- 1.** the victim was under 18 years of age;
- 2.** the victim did not have the capacity (as defined by the Mental Capacity Act 2005) to reach an informed decision to commit suicide;
- 3.** the victim had not reached a voluntary, clear, settled and informed decision to commit suicide;
- 4.** the victim had not clearly and unequivocally communicated his or her decision to commit suicide to the suspect;
- 5.** the victim did not seek the encouragement or assistance of the suspect personally or on his or her own initiative;
- 6.** the suspect was not wholly motivated by compassion; for example, the suspect was motivated by the prospect that he or she or a person closely connected to him or her stood to gain in some way from the death of the victim;
- 7.** the suspect pressured the victim to commit suicide;
- 8.** the suspect did not take reasonable steps to ensure that any other person had not pressured the victim to commit suicide;
- 9.** the suspect had a history of violence or abuse against the victim;
- 10.** the victim was physically able to undertake the act that constituted the assistance him or herself;
- 11.** the suspect was unknown to the victim and encouraged or assisted the victim to commit or attempt to commit suicide by providing specific information via, for example, a website or publication;
- 12.** the suspect gave encouragement or assistance to more than one victim who were not known to each other;
- 13.** the suspect was paid by the victim or those close to the victim for his or her encouragement or assistance;

- 14.** the suspect was acting in his or her capacity as a medical doctor, nurse, other healthcare professional, a professional carer [whether for payment or not], or as a person in authority, such as a prison officer, and the victim was in his or her care; [1]
 - 15.** the suspect was aware that the victim intended to commit suicide in a public place where it was reasonable to think that members of the public may be present;
 - 16.** the suspect was acting in his or her capacity as a person involved in the management or as an employee (whether for payment or not) of an organisation or group, a purpose of which is to provide a physical environment (whether for payment or not) in which to allow another to commit suicide.
- 44.** On the question of whether a person stood to gain, (paragraph 43(6) see above), the police and the reviewing prosecutor should adopt a common-sense approach. It is possible that the suspect may gain some benefit – financial or otherwise – from the resultant suicide of the victim after his or her act of encouragement or assistance. The critical element is the motive behind the suspect's act. If it is shown that compassion was the only driving force behind his or her actions, the fact that the suspect may have gained some benefit will not usually be treated as a factor tending in favour of prosecution. However, each case must be considered on its own merits and on its own facts.

Public interest factors tending against prosecution

45. A prosecution is less likely to be required if:

- 1.** the victim had reached a voluntary, clear, settled and informed decision to commit suicide;
- 2.** the suspect was wholly motivated by compassion;
- 3.** the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
- 4.** the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
- 5.** the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;
- 6.** the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

- 46.** The evidence to support these factors must be sufficiently close in time to the encouragement or assistance to allow the prosecutor reasonably to infer that the factors remained operative at that time. This is particularly important at the start of the specific chain of events that immediately led to the suicide or the attempt.
- 47.** These lists of public interest factors are not exhaustive and each case must be considered on its own facts and on its own merits.
- 48.** If the course of conduct goes beyond encouraging or assisting suicide, for example, because the suspect goes on to take or attempt to take the life of the victim, the public interest factors tending in favour of or against prosecution may have to be evaluated differently in the light of the overall criminal conduct.

In summary, referring to Clause 45 (which is set out above in this resource) Chris Philp explained that the conditions set out by the DPP have some flexibility, commenting that:

'...If those conditions are met, the Director of Public Prosecutions would be less likely to bring a prosecution – not completely unlikely, but less likely. The judgment as to whether a prosecution serves the public interest is an independent question for the Crown Prosecution Service, or the Procurator Fiscal Service in Scotland.'

Chris Philp went on to explain that:

'Between April 2009 and July 2019, the police referred 152 cases related to this issue to the Crown Prosecution Service in England and Wales; I regret that I do not have the figures for Scotland. Of those 152 cases, 104 cases were not proceeded with by the CPS; 29 cases were withdrawn by the police; three cases were prosecuted successfully; one case was prosecuted unsuccessfully, which is to say that it went to court but the jury acquitted; three cases remain outstanding; and eight cases led to prosecutions for a different criminal offence.'

The present Government remains neutral, as does the Royal College of Surgeons and the British Medical Association (BMA) on the matter of a change in the law, see www.bma.org.uk/advice-and-support/ethics/end-of-life/physician-assisted-dying.

In relation to counselling and psychotherapy, the law leaves unclear the specific position of a therapist who is working with a client who expresses suicidal feelings or suicidal intent, or who is actively contemplating suicide. The reason for this is that each case has to be decided on its own merits, according to the law and the principles expressed in the DPP policy.

Not all clients who are thinking about or discussing suicide will intend to carry it out.

The therapist who is working with a client who is discussing suicide should consider very carefully the client's present psychological state, needs, feelings, and issues, in the current context of the client's life, and, where appropriate, assess whether there is a real and imminent risk of the client's suicidal thoughts becoming a plan, or suicide being carried out. Therapy may help the client to consider their situation and their feelings and options in relation to it, and possibly also to access additional sources of help and support and so avert the risk.

If a client in therapy is expressing a clear intention to carry out suicide and there is a real and imminent risk that they may continue with a suicide plan, the therapist's response will be guided by the ethical and legal position appropriate to their role, and where necessary by advice in supervision and/or from another relevant legal or other suitably qualified and experienced professional. (For additional relevant information on ethics and practice see Reeves and Bond 2021; Mitchels and Bond 2021; Reeves 2010; GPiA 042 Fact Sheet *Talking about suicide risk with clients in the counselling professions*; GPiA 014 LR *Managing confidentiality*; GPiA 057 LR *Suicide in the context of the counselling professions*.)

It is clear from the general mental health law and also the DPP policy that the very high level of the duty of care owed to a client under the age of 18, or a client who lacks mental capacity, makes it likely, perhaps inevitable, that any therapy received by the client may be explored in detail by the police or the Coroner if such a client then carried out suicide.

The author is not aware of any cases in which the courts have tried a counsellor or psychotherapist under this law in relation to their therapeutic alliance with a client who is contemplating suicide, but, as practitioners, we need to understand that the way in which the courts would define 'an act capable of encouraging or assisting the suicide or attempted suicide' has been left open for interpretation. Therapists very frequently work with clients who have some level of suicidal ideation (which may develop into a suicidal intention), and exploration of these issues is a part of our professional work.

The DPP has not issued specific guidance designed for counselling professionals on this issue, but a competent therapist exploring these issues with a client and acting within the boundaries of their professional ethical framework, using appropriate risk assessment and referral where necessary, would be unlikely to be accused of intentionally encouraging or assisting suicide as defined in the legislation. Risk assessment necessarily requires careful ethical and practice consideration, appropriate professional supervision and access to other relevant expert assistance where necessary, for example the client's GP or specialist mental health services.

For more on practice issues, including appropriate risk assessment, please see BACP's GPiA 042 Fact Sheet: *Talking about suicide risk with clients in the counselling professions*; and (Reeves 2010).

Therefore, while remaining unafraid to ethically explore and engage with the issues of suicidality with our clients in therapy, we should simply bear the law in mind, and be careful to avoid acting in any way that might constitute (or be interpreted by the client or others as constituting) intentional encouragement or assistance to carry out or attempt suicide as set out in the Act. It is an ethical responsibility to keep appropriate records, and in this situation, it is wise to ensure that clear and accurate therapeutic records are maintained, because in the event of the death of the client, both police and the Coroner may ask to see the therapy records under a court order.

5 Duty of care in relation to clients considering assisted suicide

We have a duty of care to all clients, ethically, contractually and under the law of tort. When a client is exploring suicidal ideation or intention, that duty of care may include careful risk assessment, regular monitoring and reviews of risk levels, and where appropriate and necessary, referral, e.g. for specialist medical or psychiatric services.

In assisted dying, the client is involving others in bringing about their death, and so the matter is more complex.

Careful thought should be given to the client's expressed intentions and wishes in the therapeutic alliance, and it is vital to have considered discussion of the issues in supervision and/or with experienced legal or other advisors. For additional information on ethics and practice see (Reeves and Bond 2021; Mitchels and Bond 2021; Reeves 2010; GPiA 014 LR *Managing confidentiality*, GPiA 042 FS *Talking about suicide risk with clients in the counselling professions*, and GPiA 057 LR *Suicide: issues for the counselling professions*).

6 Assessment and referral of clients considering assisted suicide

Some mental conditions may carry with them an increased risk of suicidality or other forms of self-harm, while some physical conditions and medications may carry a degree of risk of depression, anxiety or suicidality. A client may therefore form a plan for suicide, or an assisted death as a response to a number of factors, including mental illness, which are capable of change or amelioration, and this may be a matter for discussion in the course of the therapeutic alliance.

For some discussion of these assessment issues in the context of therapy practice, see BACP's GPiA 042 FS: *Talking about suicide risk with clients in the counselling professions*; and Reeves 2010.

Medications and physical or mental illnesses or disabilities present many challenges for both client and therapist. There is a duty under the *Ethical Framework* (BACP 2018) to work within our competence, and the courts would regard it as an unacceptable risk for a therapist to work with a client who challenges the practitioner beyond the remit of their competence. Therefore, it is ethical practice to take advice in supervision or from a relevant experienced professional in circumstances where mental disorder or physical or mental illness is as yet undiagnosed, but is suspected by the therapist in the course of working with a client, and/or where our competence may in any way be in doubt or if we feel unable to provide the level or type of therapy that the client needs.

A therapist who is working with a client who is asking for help and assistance in carrying out their death, may decide that (following careful risk assessment, and consultation in supervision), a referral to specialist services may be the best way to help that client, consistent with the therapist's ethical responsibilities and duty of care. Referrals in this situation could be made with client consent, or possibly without client consent if the referral can be justified on an ethical and legal basis.

In the case of a risk of serious harm to the client or to others, confidentiality may be breached in the public interest – see *Confidentiality and Record Keeping in Counselling and Psychotherapy 3rd Edition* (Mitchels and Bond 2021); GPiA 014 Legal Resource: *Managing confidentiality within the counselling professions*; and (Reeves and Bond 2021). Judging what is in the public interest may require careful discussion in supervision or with experienced colleagues or legal advisors. Disclosure should be made on a 'need to know' basis to the persons or organisations, which can act effectively to prevent the intended harm, providing as much information as is necessary in order to prevent the harm, and the disclosure should be properly recorded.

Disclosures are best made with the client's knowledge and consent, and in a manner appropriate for the client, so confidentiality should always be negotiated as part of the contract between therapist and client. The client should also be informed of any limitations on confidentiality before therapy commences, and the therapist should ensure, wherever possible, that the client understands and agrees these limitations. See the *Caldicott Review: information governance in the health care system* (DH 2013, updated 2020) for guidance on disclosures within the NHS, *Information sharing: advice for practitioners providing safeguarding services to children, young people, parents and carers* (DoE 2015, updated 2018) and the GMC online guidance Good Medical Practice at www.gmc-uk.org.

Clients and their circumstances vary. Others may differentiate between client situations, recognising that there is not necessarily a 'one-size-fits-all' approach to the law, or to ethical practice. Suicide in itself is not illegal but assisting the death of another person remains a criminal offence and may put that person at risk of prosecution even though the DPP may decide in certain circumstances not to prosecute (see the DPP policy (MoJ 2014) discussed in part 4).

Some therapists may feel that certain clients exploring the issue of assisted dying (for example those who are terminally ill) should have the power to make decisions about their own life, or death, and the therapist does not wish to interfere with the client's autonomy, but to support the client through a potentially difficult time, but this presents complex ethical issues. Unlike suicide, in requesting assisted death, the client is involving others in bringing about their death.

This raises ethical issues which the therapist is recommended to explore thoroughly in supervision and/or with trusted colleagues or other appropriate professionals.

The duty of care does not necessarily require referral in all cases where a client is contemplating assisted suicide, but, as we have seen, there are additional ethical issues here, plus evaluation of the legal definition of an act which intentionally encourages or assists the suicide of another alongside the operation of the DPP policy.

7 Confidentiality, disclosures and consent

The client has a general right to expect confidentiality within a professional relationship, but this is not an absolute legal right, since confidentiality is always subject to the requirements of the law, for example in certain situations (like terrorism, or where records are subject to other statutes or court orders) compulsory disclosures must be made. There is a strong professional and legal assumption that clients ought to be informed in general terms about any limitations to confidentiality and that disclosures ought to be managed on the basis of the client's informed consent or otherwise made on a legally justifiable basis, such as the public interest.

In relation to clients with suicidal ideation or intent, disclosures and referrals should wherever possible be made with the client's knowledge and consent.

If the client does not consent, then a disclosure may be justifiable in the public interest if the likelihood of serious harm to the client or others is imminent, and the risk is significant.

A current risk assessment is therefore necessary in this situation and should be included in the case records along with the details of the disclosure made, including date, method of disclosure, person to whom disclosure is made, summary of the information disclosed, and reasons for doing so without client consent.

For further information on confidentiality and disclosures, see *Confidentiality and record keeping in counselling and psychotherapy* (3rd Edition) (Mitchels and Bond 2021); GPiA 014 LR: *Managing confidentiality within the counselling professions*; *Standards and Ethics for Counselling in Action* (5th edition) (Reeves and Bond 2021); and *Working with Risk in Counselling and Psychotherapy* (Reeves 2015). For information on working with suicidal clients and risk assessment, see *Working with Suicidal Clients* (Reeves 2010).

For the UK General Data Protection Regulation (UK-GDPR) information, please see GPiA 105 LR: *the UK General Data Protection Regulation (UK-GDPR) legal principles and practice notes for the counselling professions*.

7.1 Mental capacity (adults)

A person's mental capacity is relevant in therapy when considering whether someone can give valid consent to receive therapy or to the terms on which therapy is being provided or agree to a referral, including their wishes about the management of confidentiality, privacy and referrals. Some adults will have intermittent mental capacity to make specific decisions. Note: the mental capacity to make any particular decision may be affected temporarily or permanently by illness, ability, substance use or abuse, medications, and psychological response to stressful or traumatic life events. Capacity to give valid consent is situation specific, and may depend upon a number of factors, notably:

- for what action is consent being sought?
- have all the potential benefits, risks and consequences of taking or not taking that action been fully explained and understood?
- has the person retained the information long enough to properly evaluate it when making their decision?
- can the person clearly communicate their decision (with help as appropriate) once it is made?
- is the consent sought for the individual concerned, or is it for the treatment of another person?
- if consent is sought for another person, is that person an adult or a child?
- if consent is sought for a child, does the person giving consent have parental responsibility for the child? (for mental capacity in relation to children and young people under 18).

For adults, the law relating to mental capacity is now governed by the Mental Capacity Act 2005, the Mental Health Act 2007 and the Mental Capacity Act 2005 (Appropriate Body) (England) Regulations 2006 S.I. 2006 No. 2810. Collectively these are referred to here as the 'MCA'.

An explanation of the law and a list of relevant publications and websites are in GPiA 029 *Mental health law in the counselling professions*.

For legal issues relevant to working with vulnerable adults see GPiA 030; and for a discussion of legal issues relevant to working with children and young people see GPiA 031 LR *Safeguarding children and young people*.

If a suicidal client lacks mental capacity (this can be temporary, e.g. through illness, or long term), the MCA provides a legal framework for others to act and make certain decisions on their behalf, in their best interests, including where the decision is about care and/or treatment (see Mental Health Act 1983: Code of Practice (DH 2015: 96), and the BMA's Mental Capacity Toolkit (BMA 2020)).

As suicide is not a legal offence, an adult with full mental capacity has the legal power to decide to end their own life. The statutory powers under the MCA will only come into operation if that person lacks mental capacity. See the MCA, Mental Health Act 1983: Code of Practice (DH 2015: pp 98-99, para 13.14), for the five statutory principles underpinning actions under the MCA. In particular, when considering referral of a suicidal client who lacks capacity for in-patient mental health treatment, particularly on a compulsory basis, these principles may apply:

- Principle 4 – an act done, or decision made, on behalf of a person who lacks capacity, must be done, or made, in their best interests.
- Principle 5 – before the act is done, or the decision is made, regard must be had as to whether the purpose of the act or the decision can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Therapists in private practice may be employed by the NHS (under a contract of service) or they may be commissioned to work on a self-employed basis (under a contract for services) as part of an NHS team for the holistic healthcare of a patient.

The contract in either case will usually bind the therapist to work within the boundaries relevant to the NHS, and their actions will then be subject to the appropriate regulations and government guidance. The therapist will be expected to share information with the healthcare team on a need-to-know basis in accordance with the Caldicott guidelines (DH 2013).

In the case of private practice work, if there is concern about the safety or welfare of the client or others, apart from making an appropriate referral where necessary, the therapist is less likely to be involved in any subsequent mental health decision making process concerning the client, unless invited to do so by the mental health team.

7.2 Mental capacity (children and young people under the age of 18)

The Children Act 1989 defines a child as 'a person under the age of 18' (s.105). For a discussion of legal issues relevant to working with children and young people see Good Practice in Action Legal Resources: 002 and 026 *Counselling in schools (England, Wales, Northern Ireland and Scotland)*; 003 and 005 *Adoption law within the counselling professions in England, Wales and Northern Ireland*.

If a child or young person is exploring assisted suicide, our duty of care requires very careful ethical and legal consideration of their mental capacity to make decisions and their contextual situation.

A young person under the age of 18 is legally a child and entitled to protection under the law. If that child has mental illness, disability or psychiatric disturbance, they may also be subject to other legislation, including the provisions of the Children and Young Persons Act 1989, the Mental Health Act 1983, the Mental Capacity Act 2005 and Mental Health Act 2007. Mental health decisions regarding children and young persons should also be subject to the provisions of the Human Rights Act 1998 and the UN Convention on the Rights of the Child.

The law on a child's capacity to make decisions, and other people making decisions for a child, is vitally important for all practitioners who work with children and young people. A child's (or adult's) mental capacity to make any particular decision is not only situation specific, but may also be affected temporarily or permanently by illness, ability, substance use or abuse, medications, and psychological response to stressful or traumatic life events.

The law regarding mental capacity and consent in relation to children and young people is fully explored in other BACP publications: see GPiA Legal Resources: 029 *Mental health law within the counselling professions*; GPiA 014 *Managing confidentiality within the counselling professions* and GPiA 031 *Safeguarding children and young people in England, Wales and Northern Ireland*.

The courts will always put the welfare of a child or young person under 18 as its primary consideration, and the *Ethical Framework* (BACP 2018) states our commitment to make our clients our primary concern, and also reflects our high level of care for children and young people. Although a young person over the age of 16 may have the legal and mental capacity to make their own decisions in most areas of their life, remember that mental capacity is situation specific, and where a therapist is aware that a person under the age of 18 is requesting help for assisted suicide, appropriate professional consultation (e.g. in discussion in supervision and possibly also legal assistance) will be necessary. It is likely to be helpful in these circumstances to refer the client for any appropriate specialist social, medical and/or psychiatric support.

8 Possible new law in the making

Some people experiencing terminal illness have challenged the law, seeking permission in advance for them to have an assisted death. In these cases, they sought either a change in the law, or at the very least, a clear policy from the DPP about whether prosecution would follow an alleged offence of assisting the suicide of another person.

These cases led to the revision of the Director of Public Prosecution's Guidance *The Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* discussed in Part 3 of this resource, which was first issued in February 2010, and subsequently updated in October 2014.

Since that date, there have been repeated attempts to introduce new law. In 2015, an *Assisted Dying Bill*, was brought before Parliament, and was introduced to the House of Lords. It was designed to enable terminally ill competent adults to be provided, at their request, with specified assistance to end their own lives, but it made no further progress.

In May 2021, a new Private Member's Bill was introduced to the House of Lords by Baroness Meacher, the Chair of *Dignity in Dying*. The progress of the **Assisted Dying for Terminally Ill Adults Bill [HL]** can be tracked on the UK Parliament's Parliamentary Bills website at <https://bills.parliament.uk/bills/3741>.

Although the Bill at that time had passed its second reading in the House of Lords, it had progressed no further. The debate is recorded in the Hansard. In that debate, Baroness Meacher (Chair of *Dignity in Dying*) stated that:

'We have seen a radical shift in the views of doctors. In 2019, the Royal College of Physicians ended its opposition to assisted dying. Last month, the BMA did the same thing following a survey that showed that 50% of its members supported assisted dying and 39% were against.

My belief is that, about 10 years ago, maybe 5% of doctors supported assisted dying. The change has been extraordinary. I had a meeting with the Royal College of Surgeons the other day. It is considering reviewing its position. If it does, all the royal colleges will have moved from opposition to neutrality.'

Baroness Bakewell said, referring to earlier attempts to change the law –

'The group supported Paul Lamb, left paralysed and in daily pain after a car accident, who, with his fellow activist Tony Nicklinson, spearheaded the 2012 legal bid to change the law on assisted dying. In its landmark judgment on that case in 2014, a majority on the Supreme Court ruled that they were indeed open to changing the law on assisted dying, but they felt that Parliament should first debate the matter. That is where we are today.'

She went on to speak of the safeguards in the Bill and concluded –

'The Bill does not threaten the disabled. They are not ill and they are not dying in agony. It does not threaten people who feel they are a burden to those around them. They are not ill or dying in agony. The safeguards are many. The involvement of responsible people is mandatory. This is a measure of great humanity ringed around with practical and moral constraints. It deserves our support.'

Others expressed concern regarding the possibility of failure of the Bill's safeguards and consequent abuse of the elderly and infirm, Lord Hunt of King's Heath said –

'In the UK, financial abuse by family members has typically been the most common abuse reported to the Hourglass helpline. This charity, dedicated to ending the harm, abuse and exploitation of older people, reports that a staggering 1 million people over 65 are victims of abuse every year.'

We debated this extensively on the Domestic Abuse Act. I question whether we can take the risk inherent in the Bill.'

Current stage of changes in the law

It is understood that in March 2024, before the Election of the present new Labour Government on 4 July 2024, Keir Starmer shook hands with Esther Rantzen and agreed that if the Labour party won the election, he would not to let it go too long before the new Government would progress the Bill.

Following the success of the Labour party in the general election, the Prime Minister Sir Keir Starmer in an [interview with LBC](#) (Friday 12 July) confirmed his commitment to making time for an assisted dying bill with a free vote. This follows Sir Keir's commitment in March to Dame Esther Rantzen – a vocal advocate for law change following her diagnosis of stage four lung cancer – that he would ensure parliamentary time for debate, and reaffirmed his longstanding personal support for legalisation.

In that interview, Sir Keir also referred to his time as Director of Public Prosecutions, when he personally made dozens of decisions on whether to prosecute people for compassionately helping their loved ones to end their own lives.

Sir Keir was the head of the CPS as Director of Public Prosecutions, when – prompted by the case of Debbie Purdy – the DPP set out the factors that prosecutors should take into account in favour and against prosecution in cases of 'assisting or encouraging a suicide'. For details of this please see Part 4 of this resource.

Now, in 2024, on 26 July, under the newly elected Government, the Bill was again introduced to the House of Lords by Lord Falconer of Thoroton, Hansard records that it was read a first time and ordered to be printed. Hansard also records that it was debated on Friday 26 July 2024, but there is no record of the content of that debate at the time of writing. The next debate is scheduled for the House of Lords on 15 November 2024.

The full text of the Bill can be downloaded at [https://hansard.parliament.uk/lords/2024-07-26/debates/06CDDC83-BC37-45A3-90D9-FBA7D5B6E5E4/AssistedDyingForTerminallyIllAdultsBill\(HL\)](https://hansard.parliament.uk/lords/2024-07-26/debates/06CDDC83-BC37-45A3-90D9-FBA7D5B6E5E4/AssistedDyingForTerminallyIllAdultsBill(HL)).

The Isle of Man's parliament, the Tynwald, in the House of Keys, has now progressed its Assisted Dying Bill to a scheduled third reading. For more on this see the website www.dignityindying.org.uk/latest/news.

About the author

Dr Barbara Mitchels, PhD, LL.B, BACP Registered (Snr Accred), is a Fellow of BACP with a counselling and supervision practice in Devon. Also a retired solicitor, Barbara provides professional consultancy, resources and CPD workshops in law, ethics and therapy-related professional issues. See www.therapylaw.co.uk.

Cases

Gillick v West Norfolk and Wisbech Area Health Authority. 1986. AC 112. www.bailii.org/uk/cases/UKHL/1985/7.html

Regina (Pretty) v Director of Public Prosecutions, Secretary of State for the Home Department (interested party); Medical Ethics Alliance and others [2001] QBD 18 October 2001

Pretty v United Kingdom (2002) 35 EHRR 1 and R (Pretty) v Director of Public Prosecutions (Secretary of State for the Home Department intervening) [2002] 1 AC 800

R (Purdy) v Director of Public Prosecutions [2010] 1 AC 345

R (Purdy) v Director of Public Prosecutions (Society for the Protection of Unborn

Children intervening) [2009] WLR (D) 271; [2009] UKHL 45 House of Lords (E)

R (on the application of Nicklinson and another); (Appellants) v Ministry of Justice

(Respondent); R (on the application of AM) (AP) (Respondent) V The Director of Public Prosecutions (Appellant); R (on the application of AM) (AP)

(Respondent) V The Director of Public Prosecutions (Appellant) Trinity Term [2014] UKSC 38 On appeal from: [2013] EWCA Civ 961

For the full judgment, and comments on earlier cases, see www.supremecourt.uk/cases/uksc-2013-0235.html

In the matter of Alfie Evans: www.supremecourt.uk/cases/docs/alfie-evans-reasons-200318.pdf (accessed 13 August 2024)

In the matter of Charlie Gard: www.supremecourt.uk/cases/docs/charlie-gard-190617.pdf (accessed 13 August 2024)

An NHS Trust and others (Respondents) v Y (by his litigation friend, the Official Solicitor) and another (Appellants), [2018] UKSC 46; www.supremecourt.uk/cases/uksc-2017-0202.html (accessed 13 August 2024).

Statutes

Children Act 1989

Children and Young Persons Act 1969

Children and Young Persons Act 2008

Coroners and Justice Act 2009

Criminal Law Act 1967

Criminal Jurisdiction Act 1975

Data protection Act 2018

Family Law Reform Act 1969

Family Law Reform Act 1987

Freedom of Information Act 2000

UK-General Data Protection Regulation 2018, updated 2021

Homicide Act 1957

Human Rights Act 1998

Mental Capacity Act 2005

Mental Health Act 1983

Mental Health Act 2007

Suicide Act 1961

Tribunals, Courts and Enforcement Act 2007

Statutory instruments

Mental Capacity Act 2005 (Appropriate Body) (England) Regulations 2006 S.I. 2006 No. 2810

The Mental Health (Approved Mental Health Professionals) (Approval) England Regulations 2008 SI 2008/1206

Parental Responsibility Agreement Regulations 1991, SI 1991/1478

Parental Responsibility Agreement (Amendment) Regulations 1994, SI 1994/3157.

Conventions and protocols

- UN Convention on the Rights of the Child
- European Convention for the Protection of Human Rights and Fundamental Freedoms
- Protocols made under the European Convention for the Protection of Human Rights and Fundamental Freedoms.

References and further reading

Note:

- *UK Government* publications available from the Stationery Office (TSO, www.tsoshop.co.uk), PO Box 29, Norwich NR3 1GN. Tel: 0870 600 5522; Email: customer.services@tso.co.uk.
- *The Department for Education* www.education.gov.uk, formerly Department for Children Schools and Families, publishes policy regarding children's services in England.
- *The Ministry of Justice* www.justice.gov.uk publishes policy regarding the courts and tribunals in England and Wales.
- *Northern Ireland Government* publications are available from the Department of Health, Social Services and Public Safety www.dhsspsni.gov.uk.
- *Welsh Government* publications, see www.gov.wales/publications.

American-Psychiatric-Association *Diagnostic and Statistical Manual of Mental Disorders* DSM-5-TR. Washington D.C., American Psychiatric Association. As amended in 2015 and updated annually each October, see www.psychiatry.org/psychiatrists/practice/dsmm (accessed 13 August 2024)

British Association for Counselling and Psychotherapy (BACP) (2018) *Ethical Framework for the Counselling Professions*. Lutterworth: BACP. Available at: www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions.

British Association for Counselling and Psychotherapy (BACP) Good Practice in Action 014 Legal Resource: *Managing confidentiality within the counselling professions* (Mitchels, B., Bond, T.), Lutterworth: BACP.

British Association for Counselling and Psychotherapy (BACP) Good Practice in Action 057 Legal Resource: *Suicide: issues for the counselling professions in England and Wales*. (Mitchels, B.), Lutterworth: BACP.

British Association for Counselling and Psychotherapy (BACP) Good Practice in Action 029 Legal Resource: *Mental health law within the counselling professions in England and Wales*. (Mitchels, B.), Lutterworth: BACP.

British Association for Counselling and Psychotherapy (BACP) Good Practice in Action 105 Legal Resource: *the United Kingdom General Data Protection Regulation (UK-GDPR) legal principles and practice notes for the counselling professions*. (Mitchels, B.), Lutterworth: BACP.

British Association for Counselling and Psychotherapy (BACP) Good Practice in Action 030 Legal Resource: *Safeguarding vulnerable adults within the counselling professions in England and Wales*. (Mitchels, B.), Lutterworth: BACP.

British Association for Counselling and Psychotherapy (BACP) Good Practice in Action 031 Legal Resource: *Safeguarding children and young people*. (Mitchels, B.), Lutterworth: BACP.

British Association for Counselling and Psychotherapy (BACP) Good Practice in Action 042 Fact Sheet: *Talking about suicide risk with clients in the counselling professions* (Reeves, A), Lutterworth: BACP.

(All BACP GPiA resources available at www.bacp.co.uk/gpia)

Bartlett, P., Sandland, R. (2014) *Mental Health Law: Policy and practice*. 4th Edition Oxford: Oxford University Press.

BMA (updated April 2023) *Mental Capacity Act tool kit*. London: BMA. www.bma.org.uk.

BMA Assisted Dying: Ethical Position see www.bma.org.uk.

Crown Prosecution Service (CPS) *Code for crown prosecutors*. (2018) Available at www.cps.gov.uk

Department of Health (2020) *No Secrets: guidance on protecting vulnerable adults in care*. www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care (accessed 13 August 2024).

Department of Health (2007) *Mental Capacity Act 2005 Code of Practice* www.legislation.gov.uk.

Department of Health (2015, updated 2017) *Mental Health Act 1983: Code of Practice* available at www.gov.uk/government/publications/code-of-practice-mental-health-act-1983 (accessed 13 August 2024).

Department of Health (2016) *Care and Support Statutory Guidance* available at www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance (accessed 13 August 2024).

Department of Health (2013, updated 2020) *Caldicott Review: information governance in the health and care system* April 2013 www.gov.uk/government/publications/the-information-governance-review (accessed 13 August 2024).

Department of Health (2009) *Guide to Consent for Examination or Treatment*. www.gov.uk.

Department of Health (DoH) (2003) *Confidentiality: NHS code of practice*. London: Department of Health. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/200146/Confidentiality_-_NHS_Code_of_Practice.pdf (accessed 13 August 2024).

General Medical Council *Good Medical Practice*. London: GMC. Available at: www.gmc-uk.org (accessed 13 August 2024).

Please note that embedded in this updated online guidance document, are all of the GMC's current subsidiary guidance, for example, on Confidentiality and Consent.

Hale, B. (2017) *Mental Health Law : 6th Edition*. London: Sweet & Maxwell.

Hershman and McFarlane *Encyclopaedia of Children Law and Practice*. Loose-Leaf. Bristol: Family Law.

IACP (2018) *Code of Ethics and Practice* (Information Sheet 7). Wicklow: Irish Association for Counselling and Psychotherapy. Available at <https://iacp.ie/iacp-code-of-ethics> (accessed 13 August 2024).

ICO *Guide to the General Data Protection Regulation*. Available at: <https://ico.org.uk>.

Jackson, E. (2019) *Medical law, texts and materials*. 5th edition. Oxford: Oxford University Press.

Jones, R. (2018). *Mental Capacity Act Manual 8th Edition*. London: Sweet & Maxwell.

Mahmood, S., Doughty, J. (2019) *Child care and Protection* (6th Edition). London. Wildy, Simmonds and Hill.

Ministry of Justice (2010, updated 2014) *Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide*, available at www.cps.gov.uk.

Ministry of Justice. www.cps.gov.uk.

Mitchels, B., Bond, T (2021) *Confidentiality and Record Keeping in Counselling and Psychotherapy*. 3rd Edition. London: Sage.

Mitchels, B., Bond, T. (2012) *Legal Issues Across Counselling and Psychotherapy Settings*. London: BACP and Sage.

Pattenden, R. (2016) *The law of professional-client confidentiality: regulating the disclosure of confidential personal information*, 2nd Edition. Oxford: Oxford University Press.

Pattinson, S.D. (2017) *Medical law and ethics*, 5th Edition. London: Sweet & Maxwell.

Reeves, A. (2010) *Working with Suicidal Clients*. London: Sage.

Reeves, A. (2015) *Working with Risk in Counselling and Psychotherapy*. London: Sage.

Ruck Keene, A., K. Edwards, et al. (2017) *Court of Protection Handbook : A user's guide*, 2nd Edition. London: Legal Action Group.

Spencer-Lane, T. (2015) *Care Act Manual*. London: Sweet and Maxwell.

UK Council for Psychotherapy (UKCP) *UKCP professional occupational standards and policies*. London: UKCP. Available at: www.psychotherapy.org.uk/ukcp-members/standards-guidance-and-policies (accessed 13 August 2024).

United Nations *Convention on the Rights of the Child (1989) (ratified by the UK in 1991)* available at www.gov.uk/government/publications/united-nations-convention-on-the-rights-of-the-child-uncrc-how-legislation-underpins-implementation-in-england (accessed 13 August 2024).

Useful contacts and resources

Legal resources

- British and Irish Legal Information Institute (BAILII, www.bailii.org). Publishes all High Court, Court of Appeal and Supreme Court judgments
- Care Council for Wales www.ccwales.org.uk/child-law. Publishes *Child Law for Social Workers in Wales* in English and Welsh, with regular updates
- Family Law www.familylaw.co.uk. Access to Jordans Publishing's *Family Law Reports*
- Family Law Directory www.justicedirectory.co.uk/directory/family-law
- Family Law Week www.familylawweek.co.uk
- Justis www.justis.com. Online resource
- UK statute law (www.legislation.gov.uk)
- UK statutory instruments (www.opsi.gov.uk/stat.htm).

Regional Legal Contacts

England

For a list of the courts and links to regional courts' contact details, see www.justice.gov.uk/contacts/hmcts/courts.

For CAFCASS see www.cafcass.gov.uk National Office, 3rd Floor, 21 Bloomsbury Street, London, WC1B 3HF. Tel: 0300 456 4000; Fax: 0175 323 5249 (*local offices are listed on the website or available from National Office*).

NAGALRO (The Professional Association for Children's Guardians, Family Court Advisers and Independent Social Workers) www.nagalro.com
Nagalro, PO Box 264, Esher, Surrey, KT10 0WA; Tel: 01372 818504; Fax: 01372 818505; Email: nagalro@globalnet.co.uk.

Northern Ireland

See www.courtsni.gov.uk for contact details of all courts, publications, judicial decisions, tribunals and services.

The Northern Ireland Guardian Ad Litem Agency
Email: admin@nigala.hscni.net.

Wales

(CAFCASS) Cymru: <http://new.wales.gov.uk/cafcasscymru>.

National Office, Llys y Delyn, 107-111 Cowbridge Road East, Cardiff, CF11 9AG. Tel: 02920 647979; Fax: 02920 398540; Email: Cafcasscymru@Wales.gsi.gov.uk; Email for children and young people: MyVoiceCafcassCymru@Wales.gsi.gov.uk

EIRE: Republic of Ireland

An Roinn Slainte Dublin

Republic of Ireland Department of Health, Hawkins House, Hawkins Street, Dublin 2, Ireland. Main switchboard: 01 6354000. Dial +353 1 6354000 from outside Ireland.

Ombudsman for Children's Office Dublin

Millennium House, 52-56 Great Strand Street, Dublin 1, Ireland
Complaints free-phone 1800 20 20 40. Otherwise call 01 865 6800.
Email: oco@oco.ie; Fax: 01 874 7333.; Website: www.oco.ie.

Mental Health

Good Practice Guidance in Mental Health & Incapacity Law Scotland

www.mwscot.org.uk/good-practice (accessed 13 August 2024)

Mental Health Practice Guidance Northern Ireland

Mental Health Practice – rcni.com and www.rcni.com/mental-health-practice

MIND

www.mind.org.uk and also *Young Minds* www.youngminds.org.uk

NICE

www.nice.org.uk and www.nice.org.uk/guidance

Royal College of Psychiatrists Publications

www.rcpsych.ac.uk

Samaritans

www.samaritans.org

Suicide and Assisted death

Dignity in Dying: Home

www.dignityindying.org.uk

Society for Old Age Rational Suicide (SOARS)

www.soars.org.uk

Exit (the Scottish Voluntary Euthanasia Society)

www.euthanasia.cc/vess.html

Exit International

www.exitinternational.net