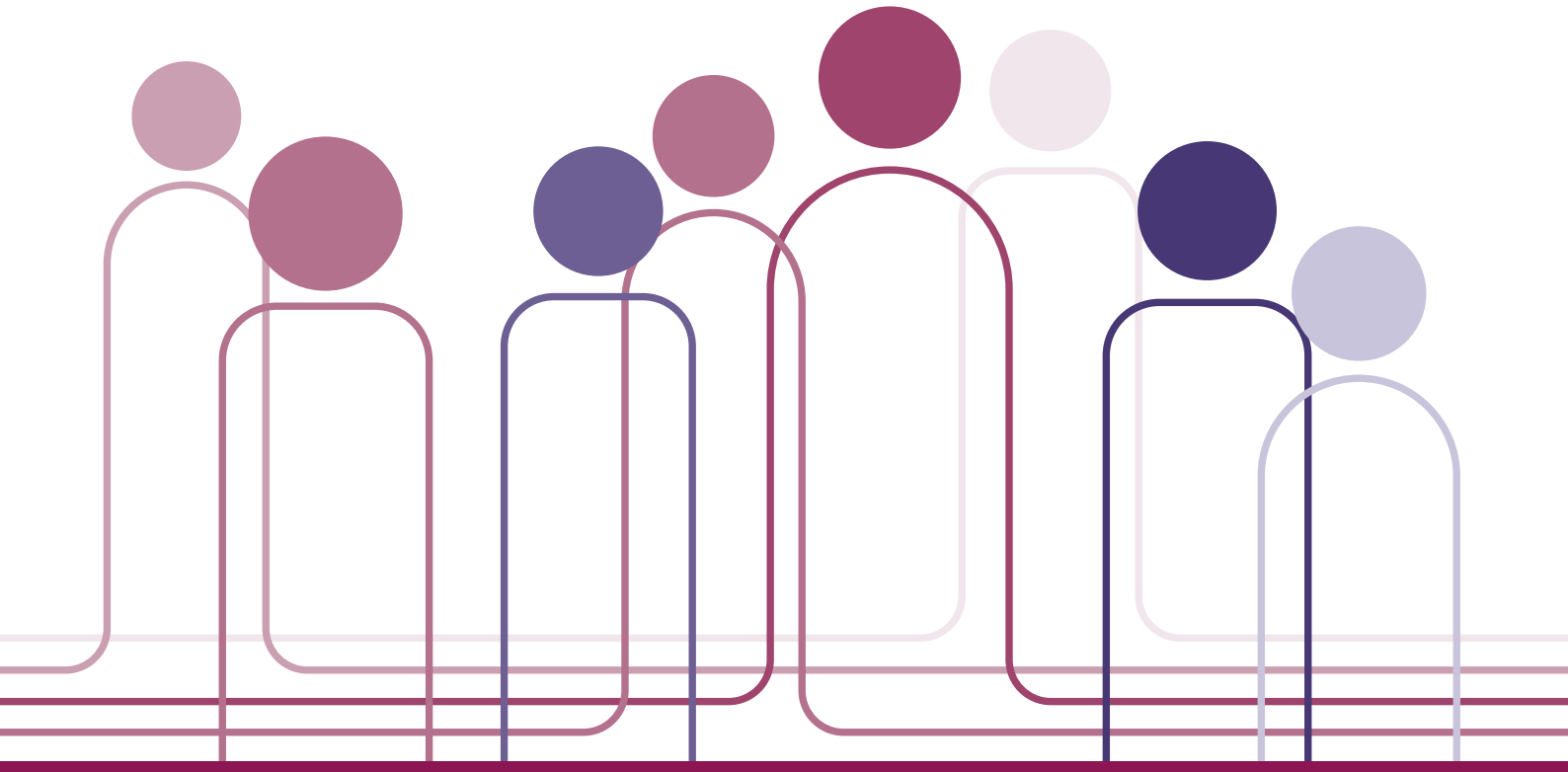
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# Suicide: issues for the counselling professions in England and Wales



Legal Resource

**Legal Resource 057**

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# Context

This resource is one of a suite prepared by BACP to enable members to engage with the current BACP *Ethical Framework* (BACP 2018) in respect of the law relating to suicide in England and Wales.

# Using the Legal Resources

The membership agreement with BACP establishes a contractual commitment by members to abide by the current *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 new *Ethical Framework* 2026 will be published in August, and will then become mandatory on 3 November 2026. Members should watch for the publication of the new *Ethical Framework* and note the implementation date, after which members will be required to abide by the new *Ethical Framework* for the Counselling Professions 2026.

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.

## Quick Guide – Where to find information

### Question


| | |
|---|---|
| What is suicide and is it legal? | Part 1 |
| What is the duty of care to a suicidal client? | Part 2 |
| When and how might I make a disclosure in relation to a suicidal client? | Parts 3, 4.2 |
| How do I assess the risk? | Part 4 |
| What is the law relating to clients in hospital? | Part 5 |
| Remote working and suicide risk | Part 6 |
| Cultural and Equality Considerations in Suicide Risk | Part 7 |
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# Introduction

This resource refers to law in relation to suicide as it applies to the provision of services by the counselling professions in England and Wales. Although some legal provisions may apply to other jurisdictions, additional statutory provisions and regulations are made for other regions in the UK. For this reason, BACP may be publishing additional resources on the law on death by suicide in relation to the counselling professions specifically in relation to Northern Ireland and Scotland.

Suicide is never an easy thing to think about, and it is a difficult subject for law making. Suicide affects not only the individual contemplating it, but also their friends, family, work colleagues and social groups. The manner of a suicide may have a direct impact on the health and welfare of others. There is also the issue of politically motivated suicide as an act of terrorism. Suicide may affect others who experience deep feelings about the loss, and the manner of the death.

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 the wide variety of situations that may present themselves.

Therapists are required under the current *Ethical Framework for the Counselling Professions* (the *Ethical Framework*) to work within the law, and so it is helpful to have a knowledge of the law as it applies to suicide and to what may be a complex therapeutic dilemma, particularly in considering our duty of care, risk assessment, consent and referral issues. The NICE guidance for healthcare and social work practitioners on recommendations and principles for assessment of suicide risk may also be helpful for members, and is available at: www.nice.org.uk/guidance.

# 1 What is suicide, and is it legal?

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

*The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* is updated annually each October. It 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 www.psychiatry.org/psychiatrists/practice/dsm.

Under section 1 of the Suicide Act 1961 it is not a criminal offence to carry out suicide.

However, doing an act that ends the life of another person could amount to the criminal offence of murder or manslaughter.

Attempts to carry out such acts may also constitute a criminal offence. See the *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (MoJ 2010, updated 2014).

## Assisting or encouraging suicide or attempted suicide is illegal

Under section 2 of that Act, 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 offence 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.

Following challenges in several court cases, (see the case list at the end of this resource), the DPP has issued guidance in relation to how decisions to prosecute would be approached, *Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide* (DPP 2010, updated 2014).

In the course of our therapeutic work, counselling practitioners may discuss and explore a client's wish to die, fear of death, or contemplation of the possibility of suicide. Part of the therapeutic role is to assess the nature and level of risk to the client or others, and to take appropriate action when necessary and ethically appropriate (see Reeves 2010, 2015; GPiA 042 Fact Sheet: *Talking about suicide risk with clients in the counselling professions*; GPiA 014 *Managing confidentiality*).

Such an 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.

The author is not aware of any cases in which the courts have tried a case brought under the criminal law against anyone in the counselling professions in relation to their therapeutic alliance with a client who was contemplating suicide and subsequently ends their own life, but this does not mean that we can ignore the possibility. Therefore, it is essential that we understand that the way in which the courts are likely to 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 one would hope that 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 the crime of intentionally encouraging or assisting suicide as defined in the legislation.

Therefore, while remaining unafraid to ethically explore and engage with the issues of suicidality with our clients in therapy, we should also be mindful of the law and be careful to avoid acting in any way that might constitute (or be interpreted by the client or others as constituting) any form of 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 (see the *Ethical Framework* Good Practice, point 15), and also a legal responsibility under the data protection legislation, (see Good Practice in Action 105 Legal Resource: *The UK-General Data Protection Regulation (UK-GDPR)*). In this situation, it is important to maintain clear and accurate therapeutic records, because in the event of the subsequent death of the client by suicide, both the police and the Coroner may ask the therapist, under a court order, to produce the therapy records relating to the work with that client.

# 2 Duty of care in relation to suicidal clients, risk assessment and referrals

## Duty of care and risk assessment

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 would include careful assessment of the client's needs and how to support their immediate and long-term psychological and physical safety; risk formulation, regular monitoring and reviews of the client's needs and risk levels, and where appropriate and necessary, referral, e.g. for specialist medical or psychiatric services.

Members should pay attention to the comprehensive NHS England guidance *Staying safe from suicide* (2025), which is informative,and is stated to be intended for not only healthcare and social care professionals, but also for other practitioners working in mental health fields. In particular, where there is a significant risk, or where there has been an episode of self-harm, the guidance highlights the importance of working in collaboration with the client, and as appropriate, other professionals and those who care for the client, to consider and meet the client's present and future care needs.

## Referral

In the course of assessment, or in therapy, the client and/or therapist may become aware of an imminent risk of death by suicide or serious harm to the client and possibly also serious harm to others. That level of risk might have developed gradually over time, or it may present in the course of therapy as arising suddenly or unexpectedly.

Following an appropriate risk assessment, and wherever possible, consultation with a supervisor or other suitably experienced colleague, a therapist may decide that referring a client who is at a significant and imminent risk of death by suicide to specialist medical or psychiatric and/or other services may be the best way to help that client, consistent with the therapist's ethical responsibilities and duty of care.

Usually, counselling practitioners will refer clients to specialist services with their client's consent, negotiated at the outset of working together as part of the therapy contract, and discussed at the time of assessment.

If that significant and imminent risk could be prevented or averted by an appropriate disclosure, confidentiality may also be breached in the public interest without client consent. If a practitioner feels that such a referral should be made, and the client has not consented, the practitioner may be legally protected from an action for breach of their therapeutic contract or for breach of their duty of confidentiality in the law of tort (referred to as a legally defensible disclosure in the public interest), provided that the practitioner can justify the referral in the public interest, on a professional, ethical and legal basis. See part 3, and also *Confidentiality and Record Keeping in Counselling and Psychotherapy 3rd Edition* (Mitchels and Bond, 2021); GPiA 014: *Managing confidentiality within the counselling professions*.

**Note:** Where a client is planning death by suicide, the proposed method of their intended death may also cause harm to others, and so may justify a breach of the client's confidentiality in the public interest, if the therapist holds a reasonable belief that the risk is real, serious and imminent.

In this event, 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 counselling commences, and the counsellor should ensure wherever possible that the client understands and agrees these limitations.

See GPiA 044 *Ethical decision-making in the counselling professions; Caldicott Review: Information Governance in the health and care system* (DH 2013, as updated 2020); *Information sharing – a practitioner's guide*. (DfE 2015); *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children*. (DfE2026); the online *BMA's Mental Capacity Toolkit* (BMA 2025); the GMC guidance *Good Medical Practice*. See also (DoH 2020) *Mental Capacity Act 2005 Code of Practice*; and (DoH 2015) *Mental Health Act 1983: Code of Practice*. Locations where these documents can be found are in the reference section.

## Non-referral

Since clients and their circumstances vary, other therapists 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 is not illegal.

Some therapists may feel that certain clients (for example those clients who are terminally ill and in severe pain that cannot effectively be relieved) who are exploring the issue of suicide should have the power to make decisions about their own life, or death. In these circumstances, the therapist may not feel it professionally and ethically appropriate to interfere with the client's autonomy, but instead to support the client in therapy to carefully reflect on and consider their wishes in a potentially complex and emotionally painful situation both for the client and their loved ones. For these reasons, the duty of care does not necessarily require referral in all cases where a client is thinking about the issue of suicide, but, as we have seen in part 1, as therapists, the law states that we cannot do any act which may intentionally encourage or assist the suicide of another person.

Ultimately whether to make an appropriate referral in these situations is an ethical issue, which the therapist is recommended to explore thoroughly in supervision and/or with trusted colleagues or other appropriate professionals.

# 3 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 (such as terrorism, or where records are subject to the requirements of 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 the 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); Good Practice in Action 014 Legal Resource: *Managing confidentiality within the counselling professions*, 2014b; Reeves, A. and Bond, T. (2026) *Standards and ethics for counselling in action* (6th edition) 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 information on the UK General Data Protection Regulation (UK-GDPR) and the Data Protection Act 2018, see BACP 2018: Good Practice in Action 105: the *UK General Data Protection Regulation* (UK-GDPR).

## 3.1 Mental capacity

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 has been 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 within the counselling professions in England and Wales*.

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

Mental capacity may be situation-dependent, and so this may potentially vary from time to time, or in different contexts. For more on this see the BMA *Mental Capacity Tool Kit* (BMA 2020) and GPiA 029 Legal Resource: *Mental health law within the counselling professions in England and Wales*. If a suicidal client lacks mental capacity (this may be of temporary duration, or it may be long term or permanent, for example lack of capacity may result from temporary or long-term illness, or it may arise from a permanent condition affecting psychological capacity or functioning), 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).

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 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 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 – see *Caldicott Review: Information Governance in the health and care system* (DH 2013, updated 2020).

Therapists working in schools or further education settings may be bound by their contract with the organisation to abide by the guidance issued by government bodies relating to working with children and young people under the age of 18, including *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* (DfE 2018, updated 2023).

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.

### 3.1.1 Mental capacity and consent for 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: GPiA 002 *Counselling children and young people in school contexts in England, Northern Ireland and Wales*; and GPiA 026 *Counselling children and young people in school contexts in Scotland*; GPiA 031 *Safeguarding children and young people within the counselling professions in England and Wales*; GPiA 042 *Talking about suicide risk with clients in the counselling professions*, and GPiA 046 *Working with children and young people*.

A young person with mental illness, disability or psychiatric disturbance 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 the 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 children's capacity to make decisions, and other people making decisions for children, is vitally important for all practitioners who work with children and young people. Whether children can enter into a formal contract for therapy will depend on whether they have the legal capacity to make their own decisions. It may be that a younger child who does not have capacity can form a therapeutic alliance (e.g. agree a mode of working with a school counsellor), and the legal boundaries of the contract for their therapy may be made with those who have parental responsibility for the child.

**Note**: 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.

### 3.1.2 Mental capacity: young people aged 16-18

Under s.8 of the Family Law Reform Act 1969, at the age of 16, a young person with mental capacity gains the right to give their informed consent to (or refusal of) medical or dental treatment, which includes psychological treatment and counselling. The consent of the young person aged 16-18 is as valid as that of an adult. Note that the MCA applies to all persons over the age of 16, and so under the MCA, the test, which will be applied for mental capacity in relation to a person aged 16 years or more, is exactly the same as that for an adult. Under s.8 of the Family Law Reform Act 1969, if a young person aged between 16-18 with capacity consents to recommended medical or dental treatment, (even if those with parental responsibility for them disagree for any reason), the medical practitioner would be protected from a claim for damages for trespass to the person.

### 3.1.3 Where a 16 to 18-year-old has capacity, but refuses consent

If a young person aged 16-18 has capacity, but refuses recommended mental health treatment, the High Court may in some circumstances (for example to save the life of the child) overrule the wishes of the young person and make an appropriate order for the welfare of the child, or an order may be made under the MHA.

In the event of a dispute between the young person and healthcare staff about admission to hospital or other consent for essential medical or psychological assessment or treatment for a mental disorder, the issue may be resolved under the MCA, as it would be for an adult (see Good Practice in Action 029 Legal Resource: *Mental health law within the counselling professions*).

In some circumstances, it will be possible for young people aged 16-18 lacking capacity to be admitted to hospital and/or treated on the basis of consent of those with parental responsibility for them (see Mental Health Act 1983: Code of Practice DH 2015: pp182-5, paragraphs 19.53 – 19.70).

However, the courts have made it clear that there are limits to the types of decisions that those with parental responsibility can make on behalf of their child, and the circumstances in which such decisions can be made.

If the decision is unsuitable for those with parental responsibility to make, then the matter may need to be referred to a court.

### 3.1.4 Where a 16-18 year old lacks capacity

Where the young person aged 16-18 is assessed under the MCA and does not have capacity, those who have parental responsibility for them should be identified, and consulted about the proposed decision (subject to the young person's right to confidentiality), see s.4 of the MCA. For the definition and scope of parental responsibility; situations where those with parental responsibility for a young person may give consent for treatment, and possible actions where there is disagreement between the child and those with parental responsibility, see Good Practice in Action 031 Legal Resource: *Safeguarding children and young people*.

Where a child or young person lacks competence or capacity, in specified circumstances they may be admitted informally with either the consent of those with parental responsibility, or the provisions of the MCA. If the specified circumstances for informal admission do not apply then, unless it is a life-threatening emergency (see *Mental Health Act 1983: Code of Practice* (DH 2015: p185 paras 19.71-72)), either they should be admitted under the formal criteria in the MCA or by an order of the High Court (either a declaration of lawfulness or an order under s.8 of the Children Act 1989), or a deprivation of liberty order by the Court of Protection for persons aged 16 and 17.

For the law relating to children and the UK General Data Protection Regulation (UK-GDPR) 2018, see also BACP Good Practice in Action 105 Legal Resource: *the UK General Data Protection Regulation* (UK-GDPR).

# 4 Assessment and management of risk and the therapist's duty of care

Working with risk is always a concern for a therapist. We have to consider any area of potential risk to the health and welfare of the client to whom we have a duty of care, and also, as part of our duty of self-care, we need to be aware of any potential risk to ourselves as practitioners – whether the risk may arise from the client's actions, or from any other aspect of the therapeutic work.

Sometimes, the client's plan to carry out suicide may involve a significant level of risk to others as a result of the method chosen, for example, a planned death on a road or train track, or the use of fire, gas or other hazardous substances. The therapist then has to consider the public interest in protecting other members of the public as well as the needs of the client.

Reeves and Bond pay attention to both areas of risk in their *Standards and Ethics for Counselling in Action* 6th Edition (2026). Andrew Reeves also pays attention to these risks in his books – *Working with Suicidal Clients* (Reeves 2010); *Working with Risk in Counselling and Psychotherapy* (Reeves 2015).

## 4.1 Risk assessment in the context of suicidality

Some mental health conditions may carry with them an increased risk of suicidality or other forms of self-harm, while other mental health conditions may carry a degree of risk of violence to others, which may put the therapist and/or others at risk.

Risk assessment is very much a matter of good practice. See GPiA 042 Fact Sheet: *Talking about suicide risk with clients in the counselling professions* and also see the NHS England guidance (2025) *Staying safe from suicide*, which states: 'The guidance applies to all mental health practitioners in England, working in both community and inpatient settings, and supporting people of all ages. It should be adopted by public, private and voluntary sector providers, including independent practitioners.'

NICE Suicide Prevention Guidance QS189 (2019) gives guidelines for risk assessment and risk management policy at www.nice.org.uk for help in good and effective risk assessment in working with suicidal clients in therapy practice.

The legal position is that the courts will expect the practitioner to take reasonable therapeutic care of each client, using appropriate therapeutic skills taking into account the circumstances of that particular client, and their specific situation.

Where there is a formal diagnosis of mental illness or a mental disorder for the client, it is advisable for the practitioner to seek guidance on the appropriate management of risk in relation to that specific client (or group of clients) from the relevant professionals responsible for the client's health and welfare. For example, where appropriate, consultation with those responsible for the client's medical, social and physical care, is advisable, acting ethically within the law and the boundaries of client confidentiality and client consent.

## 4.2 Referrals

We have a duty under the current *Ethical Framework for the Counselling Professions*, and under the new *Ethical Framework* (to be published in August 2026 and implemented on 3 November 2026) to work within our professional competence. The courts would regard it as an unacceptable risk to a client for a therapist to work with a client who presents material, issues, behaviours, or any other circumstances (e.g. age, ethnicity, social circumstance, personal qualities, or a diagnosis of specific mental illness or disorder, etc.), which may challenge the therapist beyond their competence. Therefore, we as therapists should be cautious and take advice in supervision or from a relevant experienced professional, when thinking about working with any client or circumstances in which our competence may be in any way in doubt. It is a failure of our duty of care to provide an inadequate service. We should therefore refer a client on if we feel unable to provide the level or type of therapy that the client needs.

Referrals should be made with the explicit knowledge and consent of the client, and usually will go to the client's GP or mental health practitioner. Usually, a referral would take the form of advising clients to consult their GP themselves, but if a client requires emergency assistance or is too unwell to act on their own behalf, referral may have to be made by the practitioner.

It is good practice to discuss confidentiality with clients at the outset of the therapeutic alliance, and, in advance of starting therapy, to obtain from the client a general formal consent for making appropriate referrals if necessary, and to agree how this will be done.

For more detailed exploration of confidentiality and disclosures of information see *Confidentiality and Record Keeping in Counselling and Psychotherapy 3rd Edition* (Mitchels and Bond 2021).

Referral letters form part of a client's clinical record, and so should be carefully considered and accurately worded. Not only is there a duty of care regarding accuracy in referral, but there is a legal liability for the making of a statement, whether verbal or written, which is untrue and which may damage the reputation of another person. Practitioners could also be held legally liable for inaccurate information disclosed about a client.

**Undiagnosed mental illness in a client**

If mental disorder or mental illness is as yet undiagnosed, but is suspected by the therapist in the course of working with a client, the issue of an appropriate referral should be considered and discussed in supervision or consultation with the therapist's professional organisation or an experienced colleague.

For further resources, please refer to BACP's current *Ethical Framework for the Counselling Professions* and the relevant Good Practice in Action (from November these will be Ethics in Practice resources on the BACP website at: www.bacp.co.uk/gpia.

# 5 Hospital admissions and managing suicidality in residential care

## 5.1 Admission under Section 3 of the MHA for treatment

The patient must be suffering from a mental disorder (as defined in s.1 MHA), **and** the mental disorder must be 'of a nature or degree' that makes it appropriate for him to receive treatment in hospital **and** 'it is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained and appropriate medical treatment is available for him'.

All of the above factors have to be in place for the section to operate. Some disorders may not be appropriate for hospital treatment, (e.g. they may depend on clinical and social factors) and so then this section will not apply.

If the patient has a learning disability and this constitutes the mental disorder, then s.3 can only operate if the disorder 'is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person detained' (MHA s1(2A) and (2B)(a)). It is possible that if a client has a learning disability and then also develops suicidality, then this section might apply for example, where the person intends to risk harm to others or even to kill others along with themselves. For a longer discussion of these principles, and the process of admission, see *Mental Health Law: Policy and Practice 4th edition* (Bartlett and Sandland 2013: Chapter 6), also *Mental Health Law: 6th Edition* Hale, B. (2017), Jones, R. *Mental Health Act Manual. 28th Edn* (2026) and Jones, R., Piffaretti, E. *Mental Capacity Act Manual. 9th Edition*. For the Court of Protection procedure and precedents, see Ruck Keene, A., K. Edwards, et al. (2025). *Court of Protection Handbook: A user's guide. 5th edition*.

**Compulsory detention for mental health assessment and treatment**

For a guide to good practice in the process of admissions, see the *Mental Health Act 1983 Code of Practice* (DH 2015). This is guidance and not compulsory, but a significant help to understanding definitions and also an indication of what is expected in best practice.

## 5.2 Admission under Section 2 of the MHA for assessment or under Section 3 of the MHA for treatment

Applications for admission (other than in cases of emergency) under the MHA ss.2 or 3 (as appropriate) should be made by the nearest relative of the individual or (subject to s.11 of the MHA) an 'approved mental health professional' on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement in the opinion of the practitioner the conditions set out in subsection (2) of s.2 or s.3 (as appropriate).

A compulsory admission for assessment may last for up to 28 days, subject to the provision of certificates by two doctors in the prescribed form, one a medical practitioner (usually the patient's GP) and the other a specialist in mental disorders (usually a consultant psychiatrist).

The period of 28 days is not renewable, and should be followed by discharge, continued admission as an informal patient, or a formal compulsory admission under s.3 MHA (see the section on compulsory admission under MHA s.3).

## 5.3 Emergency admissions for assessment and/or treatment under Section 4 of the MHA

Section 4 of the MHA deals with cases requiring an emergency response. In urgent cases, on the application of a nearest relative or accredited mental health practitioner, a patient may be admitted and detained for up to 72 hours by one doctor (rather than the two doctors required under ss.2-3 MHA), or when immediacy is required, for up to six hours by a nurse (s.5 MHA).

One medical certificate will suffice for an emergency application for detention under s.4 MHA for assessment in accordance with s.2, provided the second certificate is provided within 72 hours (s.4 MHA).

A Justice of the Peace may authorise detention in a place of safety for up to 72 hours under s.135 MHA, on application by an approved social worker, if the person is being ill-treated, neglected, or not kept under proper control, or living alone and unable to care for themselves in any place within the jurisdiction of the justice (s.135 MHA).

Under section 136 of the MHA, police officers currently have the power to remove a mentally disordered individual who is 'in need of care and control' from a public place and take them to a safe place for up to 72 hours. However in the future, the law might be amended to transfer the responsibility for removal of those individuals to a safe place more appropriately to the role of mental health services.

Suicidality is covered by the wording of s.2 below, which refers to the patient '... suffering from a mental disorder of a nature or degree which warrants the detention of the patient in hospital for assessment (or for assessment and treatment)...', **and** 'he ought to be detained in the interests of his own health and safety, or with a view to the protection of other persons.'

> **Note:** s.2 does not require that an appropriate treatment is available – in fact, some mental disorders may be assessed as inappropriate for inpatient hospital treatment. For other patients, the formulation of a treatment plan will be an integral part of their assessment.

For further information on the legal position regarding detainment and assessment see MHA 1983 Section 2 at: www.legislation.gov.uk/ukpga/1983/20/section/2

> **Note:** in short-term detentions, the provisions of ss.63 and 58 of the MHA 1983 regarding treatment without consent do not apply, and so the patient may refuse treatment if competent to do so.

# 6 Remote working

Counselling professionals owe the same duty of care during remote work with clients as they do when working face-to-face. Remote work refers to therapeutic contact over various media including phone, online platforms, instant chat etc.

By its very nature, remote work presents practitioners with additional considerations to bear in mind when ensuring that their working practices are legal, professional and competent. Particularly pertinent considerations include client location, assessment of risk and client suitability for remote therapeutic work, advance planning around crisis management and feasibility of emergency response.

While there may be no specific requirement for practitioners to record a client's residential address, not knowing it could hinder appropriate action during crisis, which may potentially be regarded as a breach of the duty of care. For these reasons, best practice requires that, at or before the client intake session, the practitioner identifies the client's location, along with discussion, consent and agreement with the client around crisis management, and that this is followed by regular review.

The legal position around confidentiality and consent during remote work mirrors that of in-person work in terms of duty of care and the application of statutory frameworks which allow for disclosure where necessary to protect life and prevent serious harm. For further information refer to Sections 2 and 3 of this resource, as well as: MCA 2005, DPA 2018 and UK-GDPR, Children Act 1989/2004, HRA 1998.

Practitioners should also remain mindful of the Equality Act 2010. This Act requires practitioners working face-to-face or remotely, to make reasonable adjustments to ensure clients with disabilities or access needs can participate fully in counselling.

In remote work this may mean adapting technology or providing information in alternative formats to ensure that clients can engage effectively in the therapeutic process, and, in relation to this specific guidance, in processes involving risk assessment and crisis planning and management.

Safeguarding duties for both vulnerable adults and children remain unchanged during remote working. Practitioners therefore remain bound by any existing statutory duty to refer concerns around the risk of significant harm to the client or others, to the local authority safeguarding team (see Part 3). Mental capacity, parental involvement, and Gillick competence are all factors requiring practitioners to take extra care when working online to confirm their client's identity, age, and assess mental capacity and competence, and verify any parental or carer authority before sharing information.

## Remote work with clients abroad

It is also helpful for counselling professionals undertaking remote work with clients abroad to be aware of potential jurisdictional differences between their own location and that of a client who is in a country outside the jurisdiction of England and Wales. For example, some countries have different qualifying criteria for those in the counselling professions and counselling practitioners may be required to be registered, licensed or otherwise authorised locally prior to working remotely or face-to-face with a client located in a particular jurisdiction. Furthermore, disclosure laws can also differ from country to country. For instance, whereas the law in England and Wales permits disclosure in the public interest where necessary to protect life or prevent serious harm, legal tests for breaching confidentiality in other jurisdictions may be narrower or broader, or there may be local rules of when and how to share information with emergency services or authorities. The onus is on practitioners to check and abide by the laws and regulations of the country where a client is located, as well as to ensure dual compliance with domestic law of the country from which the practitioner is working.

Practitioners should also be aware that their professional indemnity insurance does not always cover work with clients based outside the UK, which means that a practitioner could become personally liable for any claim or legal action arising in the client's country. Therefore, it is important to confirm at the outset that indemnity insurance will cover work with clients in the intended location, and to have a clear contractual agreement with the client about the terms of working, including insurance and legal liability.

Although not specifically related to suicide risk, practitioners also need to be aware of the law around data protection (see GPiA 105) and working with online encrypted platforms.

# 7 Cultural and equality considerations in suicide risk

Culturally responsive and inclusive practice is not only central to ethical counselling but is also part of counselling professionals' wider legal responsibilities. For practitioners this means considering how discrimination, stigma and social exclusion can heighten suicide risk, as well as recognising how multiple aspects of a client's identity – such as race, gender, sexual orientation, neurodiversity, disability, poverty – can overlap and intensify risk and vulnerability. Culturally sensitive practice involves awareness that risk can be increased, not just by personal factors, but by wider social and structural inequalities which can leave clients feeling unsupported or invisible to mainstream services.

Practitioners' legal responsibilities are set out in both statute and the common law duty of care. For instance, the Human Rights Act 1998 protects people's right to life, dignity, and respect for their identity and personal relationships – all of which are critical considerations when supporting people in distress and crisis.

Such principles are reinforced by the Equality Act 2010 which requires counselling professionals, as service providers, to avoid discrimination and implement reasonable adjustments to ensure that clients with any of the nine characteristics protected by the Act do not face barriers and disadvantage in accessing services.

In practice these laws ensure, for example, that a client from a minoritised faith can expect their faith to be respected and acknowledged within the therapeutic space, and that a neurodiverse client can access support without unnecessary obstacles. Such protections can be particularly significant in suicide prevention, where exclusion and stigma from other sources may already be exacerbating feelings of hopelessness and isolation.

Under the common law duty of care, practitioners are required to act with the skill and competence that could reasonably be expected of a professional in their position, and to take steps to protect clients from foreseeable harm. In the context of suicide risk – this means an appreciation of how culture, identity and lived experience may shape and impact a person's mental health and risk of suicide thoughts and behaviours. Practitioners who recognise the limits of their own perspective and take a sensitive and compassionate approach in seeking to understand each client's unique background can both reduce risk of harm and ensure their responses and service provision remain effective and lawful.

# 8 Legal considerations following a client suicide or serious harm

The death of a client by suicide can affect counselling professionals on many levels and be a profoundly distressing and disorientating time. In addition to the emotional impact, counselling professionals may experience grief, shock, anxiety around other client work, as well as self-doubt and fear of complaints and implications. Practical demands such as inquests, safeguarding enquiries and serious incident reviews can add further pressures. While navigating these varying impacts it can be helpful for counselling professionals to also remain mindful of relevant legal and professional responsibilities.

For instance, scenarios which may arise following the death of a client by suicide include requests for information about the circumstances of the death and the deceased from the media, lawyers, coroners and others.

Such requests need to be managed with care and sensitivity; however, it is important to remember that a client's right to privacy does not end with their death (*Lewis v Secretary of State for Health* [2008]). In practice this means, that confidentiality can usually only be breached in limited circumstances such as, where the client consented before their death, where there is a legal requirement (for example, a court order), or where there is an overriding public interest. So, although it is natural for families and others close to the client to seek information, they do not have an automatic right to access records, and it is important that counselling professionals refrain from sharing information without lawful authority to do so and seek guidance from insurers or legal teams to ensure that responses are handled with care.

In some instances, practitioners may also need to respond to questions or complaints raised by concerned others to workplaces and/or professional bodies (e.g. BACP), and occasionally, legal claims alleging negligence as well. Although these situations can be understandably daunting, it may be helpful to keep in mind that coroner investigations are about fact finding rather than attributing blame, and that claims of criminal liability require evidence that a duty of care was breached and caused client death. In any such circumstances, and particularly in cases of serious incidents, practitioners are encouraged to seek prompt guidance from insurers, legal advisors and, where relevant, employers' legal teams.

For counselling practitioners who are employed, it can also be helpful to be aware that employers have a legal duty under the Health and Safety at Work Act 1974 to take reasonable steps to protect the health, safety and wellbeing of their employees, including counselling professionals impacted by traumatic events. This may include occupational health, supervision, and opportunities for debriefing and reflection. Employers may also wish to undertake additional risk assessment to consider the potential for 'suicide contagion,' where one suicide increases the risk of further suicidal behaviour among others connected to the person, such as peers, colleagues, or clients.

In this context NHS postvention guidance emphasises the importance of timely, compassionate, and sustained support over one-off formal debriefs (www.nhsconfed.org/publications/nhs-employee-suicide-postvention-toolkit-impact-support).

In addition to workplace support, counselling practitioners can also seek support from professional bodies (e.g. BACP), Employer Assistance Programmes, or additional clinical supervision.

It is important to remember that following recognised good practices, maintaining thorough records, engaging in supervision and adhering to professional guidelines, all offer counselling professionals valuable protection in the event of a serious incident.

BACP's Good Practice in Action resources expand on these issues:

- GPiA 060 – *Coroner's Court, inquests and confidentiality beyond death: Issues for the counselling professions in England and Wales*
- GPiA 065 – *Confidentiality and record keeping within the counselling professions*
- GPiA 083 – *Writing reports for the courts and giving evidence in court in the context of the counselling professions in England and Wales.*

# 9 Legal definitions relevant to suicide

Below is a glossary of the basic legal terms related to suicide and mental health which are used in this resource. More complex legal terms and concepts are explained in the body of the text.

## Mental Disorder

The Mental Health Act 1983 (collectively with amendments, referred to as the MHA) states that it governs 'the reception, care and treatment of mentally disordered patients, the management of their property and other related matters.' (s.1(1)).

'Mental disorder' is the gateway provision for the operation of many parts of mental health legislation, for example, compulsory admission to hospital, detention in hospital, confinement, and warrants to search for and remove individuals believed to be ill-treated.

There is now a unified definition of mental disorder, so that a single definition now applies throughout the MHA, and complements the changes to the criteria for detention. Under s.1(2) of the MHA, '"mental disorder" means any disorder or disability of the mind; and "mentally disordered" shall be construed accordingly.'

Under s.1(2A) of the MHA, in relation to certain specified purposes, 'a person with learning disability shall not be considered by reason of that disability to be –

'(a) suffering from mental disorder... or (b) requiring treatment in hospital for mental disorder... unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.' So care should be taken when working with someone with a learning disability to assess whether ss.1(2A)-(2B) of the MHA apply.

Under s.1(4), '"learning disability" means a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning.'

Note that under s.1(3) of the MHA, 'Dependence on alcohol or drugs is not considered a disorder or disability of the mind...'.

Bear in mind, though, that in some cases, a person may have comorbid conditions additional to their alcohol or drug dependence, which could then fall within the definition of mental disorder under the MHA.

For further consideration of the range of this definition, see sections 2.4-2.13 of the Mental Health Act 1983: Code of Practice (DH 2015: pp26-27).

## Mental illness

Mental illness was not defined as a specific term in the MHA, because there was, and still remains, a general reliance on case law and medical and psychiatric practice for a definition of mental illness on a case-by-case basis.

Since the psychiatric manuals of mental disorder are constantly being updated and definitions of mental illness will change over time, this makes perfect sense, and provided that the patient's condition is defined as a category of mental illness in one of the commonly used psychiatric manuals, application of the law should follow appropriately. For an example of such a manual, see the *Diagnostic and Statistical Manual of Mental Disorders DSM-V-TR*. (American-Psychiatric-Association 2022 and updated annually). This publication is widely used in the United States, perhaps less so in the UK, and is available in hard copy. Summaries of DSM 5-TR innovations are available online, for example, see https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.03.3.28. Relevant to this resource, the DSM 5-TR Manual contains new ICD-11-CM codes to flag and monitor suicidal behaviour, and also non-suicidal self-injury, which may be useful for practitioners interested in this field to explore.

Mental illness may be mistakenly perceived by some as a range of permanently curable illnesses, in the same way that some physical illnesses may be permanently cured – this perception may be true in some instances, but mental illness may perhaps be more clearly perceived generally as a chronic condition, which may be controlled or contained with appropriate conditions of life and/or appropriate treatments.

When we think of mental health legislation, which might enforce treatments or conditions of living on people with certain serious mental illnesses, this means that legislation may affect a person with serious mental illness at various times in their life.

## Relative and nearest relative

The terms 'relative' and 'nearest relative' are defined in s.26 MHA, and ranked as 'nearest' in the order of the list. They include:

**a.** husband or wife or civil partner;

**b.** son or daughter;

**c.** father or mother;

**d.** brother or sister;

**e.** grandparent;

**f.** grandchild;

**g.** uncle or aunt;

**h.** nephew or niece.

The person with whom the patient is living or had been living before admission to hospital may also be regarded as a relative or nearest relative, provided they comply with the circumstances specified in s.26 and s.27 of the MHA. If the patient '... ordinarily resides with or is cared for by...' one of the persons on the list, they will take precedence over the others, under s.26(4) MHA.

Section 29 of the MHA gives patients the right to make an application to displace their nearest relative and enables county courts to displace a nearest relative where there are reasonable grounds for doing so.

### Supervised community treatment

Chapter 4 of the MHA 2007 introduces supervised community treatment for patients following a period of detention in hospital.

It is expected that this will allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act, to ensure they continue with the medical treatment that they need. Currently some patients leave hospital and do not continue with their treatment, their health deteriorates and they require detention again – the so-called 'revolving door'.

## Acknowledgements and about the authors

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# Cases

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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

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) 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

See also the ECHR case law Factsheet available at: www.echr.coe.int/Documents/FS_Euthanasia_ENG.pdf

# 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

United Kingdom General Data Protection Regulation (UK-GDPR) 2018

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).
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# 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.vlex.com). Online resource.
- UK statute law (www.legislation.gov.uk)
- UK statutory instruments (www.opsi.gov.uk/stat.htm).
- Disclosure and Barring Service (DBS)

## England and Wales

DBS customer services, PO Box 110, Liverpool, L69 3JD; Tel: 0870 90 90 811; Minicom: 0870 90 90 344; Welsh language line: 0870 90 90 223; Email: customerservices@dbs.gsi.gov.uk; Transgender applications: sensitive@dbs.gsi.gov.uk; www.gov.uk/dbs-update-service;

**Welsh language scheme**: www.gov.uk/government/organisations/disclosure-and-barring-service/about/welsh-language-scheme

## Northern Ireland:

information on the application process: www.nidirect.gov.uk/accessni; information on the disclosure and barring programme in Northern Ireland: www.dojni.gov.uk/accessni.

## 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) see 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

Children and Family Court Advisory and Support Service (CAFCASS) Cymru: (https://gov.wales/cafcass-cymru).

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 on 01 865 6800. Email: oco@oco.ie. Fax: 01 874 7333. www.oco.ie.

**Good Practice Guidance in Mental Health & Incapacity Law Scotland**

www.mwcscot.org.uk/good-practice

**Mental Health Practice Guidance Northern Ireland**

**Mental Health Practice**
rcni.com, www.rcni.com/mental-health-practice

**MIND**
www.mind.org.uk, www.youngminds.org.uk

**NICE**
www.nice.org.uk www.nice.org.uk/guidance

**Samaritans**
www.samaritans.org and
www.samaritans.org/how-we-can-help-you/contact-us

**Organisations relevant to assisted suicide and assisted death**

**Dignity in Dying: Home**
www.dignityindying.org.uk

**Society for Old Age Rational Suicide (SOARS)**
https://wfrtds.org/uk-society-for-old-age-rational-suicide-soars-goes-online

**Exit International**
www.exitinternational.net.