

Talking about suicide risk with clients in the counselling professions

Good Practice in Action 042 Fact Sheet

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Updated August 2024

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Design by Steers McGillan Eves.

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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 for the Counselling Professions* (BACP, 2018) in respect of suicide.

Using Fact Sheet resources

BACP Good Practice in Action resources are a series that is free to BACP members to download. It is hoped they will support good practice in the counselling-related professions. They are all reviewed both by member-led focus groups and experts in the field and are based on current research and evidence.

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.

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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 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 word 'therapist' is used to mean specifically counsellors and psychotherapists and 'therapy' to mean specifically counselling and psychotherapy. The terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care.

About this resource

The aim of this resource is to provide practitioners with an overview of the main issues they may face when working with clients who are suicidal. The areas that will be considered are:

- introduction to the issues of working with suicidal clients
- policy background
- setting a context for working with suicide risk
- recognising suicide risk
- exploring suicidal thoughts as a means of assessment
- responding to suicide risk
- confidentiality and records
- supervision and self-care.

For information on legal aspects of suicide, see Good Practice in Action 057 Legal Resource: *Suicide in the context of the counselling professions in England and Wales*.

Introduction

Clients presenting in therapy who may be at risk of suicide can be challenging for even the most experienced practitioner. Understanding the client's experience of thoughts about suicide, knowing how best to respond in the therapeutic relationship, and ultimately making collaborative decisions, wherever possible, about the implications for confidentiality, pose difficult dilemmas for practitioners. The most helpful course of action for the practitioner will be dependent upon many factors, including:

- the context in which therapy is taking place
- the relationship with the client
- the limits of confidentiality agreed with the client of confidentiality agreed
- the confidence of the practitioner to explore the meaning of suicide.

Practitioners can experience a range of responses when working with someone who expresses suicidal thoughts, including fear, anger and intrusive thoughts as well as a sense of professional incompetence (Reeves and Mintz, 2001; Richards, 2000). Studies suggest that suicide remains one of the most difficult therapeutic issues faced by practitioners in their professional lifetime (Scupham and Goss, 2020). Most practitioners will, at some point, work with a client who expresses suicidal thoughts and the likelihood of suicide risk presenting in therapy is not specific to any particular working context (Reeves, 2015). While suicide rates can marginally decrease or increase over time, for particular groups such as males, suicide remains one of the main causes of death (DoH 2021). It is important to remember however, that suicide is a risk that needs to be taken seriously and talked about: 17 individuals die by suicide very day in the UK with five of these being seen by mental health services; 88% of those being seen when they died by suicide were judged as being at low or no immediate risk of suicide by the clinician at their last contact. (HQIP, 2018)

1 Policy background

Over recent years the Governments across the four nations have published suicide reduction guidelines within the policy context of a suicide reduction 'agenda' (DoH, 2023; National Assembly for Wales, 2022; Northern Ireland Assembly, 2023; Scottish Government, 2013). Additionally, in January 2015 the UK Government called for a 'zero target' for suicides in the NHS, for which supporting policy has now been implemented at local level. The policy focus has therefore been centred on a reduction in suicides, which has created a context in which other mental health workers, including counselling professionals, work.

The implication of these policies for practitioners is that suicide prevention and reduction should be a priority for all. This includes the private practitioner who may work within other frames of reference such as that offered by BACP's *Ethical Framework for the Counselling Professions* (2018). Policy and practitioner documents make important statements about factors that practitioners need to consider.

For example, how practitioners determine a client's capacity to begin therapy, how contracts are agreed with clients around confidentiality, and who might be contacted to support client safety in particular circumstances eg should a client present at risk; this might, for example, include a client's general practitioner or crisis team.

What is clear however, is that practitioners need to ensure that they have clarified these issues with clients at the start of therapy as outlined in the *Ethical Framework for the Counselling Professions* 'agreeing with clients on how we will work together' (Commitment, point 3c).

2 Setting a context for working with suicide risk

2.1 Evidence-informed

Over the last two decades the trend in mental health and, increasingly in counselling and psychotherapy, has been the identification of risk and protective factors in determining the likelihood of a client acting on their suicidal thinking (Reeves, 2017). There is now overwhelming evidence that we cannot effectively predict suicide risk, and that practitioners should not focus risk-management efforts on prediction. There is also some evidence for what is known as the 'low risk paradox' where clients who have died through suicide were deemed in their later, or last contacts with professional services, to not present as being 'at risk' through the use of risk assessment tools (HQIP, 2018). However, many practitioners and academics have argued that a 'risk factor' approach is problematic in that it draws on generalised statistical trends and therefore, lacks accuracy when applied to individual circumstances.

The Royal College of Psychiatrists published an important guidance document that questioned the routine use of such risk assessment tools (RCP, 2020). In September 2022, the National Institute for Health and Care Excellence (NICE) issued direct guidance to mental health practitioners (which would include counsellors and psychotherapists) on the assessment, management and prevention of self-harm. They state:

Do not use risk assessment tools and scales to predict suicide or repetition of self-harm (1.6.1)

Do not use risk assessment tools and scales to determine who should and should not be offered treatment or who should be discharged (1.6.2)

Do not use global risk stratification into low, medium or high risk to predict future suicide or repetition of self-harm (1.6.3)

Do not use global risk stratification into low, medium or high risk to determine who should be offered treatment or who should be discharged (1.6.4)

The guidance is unequivocal against the use of risk assessment measures to predict the likelihood of suicide.

While many organisations continue to use these as part of day-to-day practice, which might include counsellors and psychotherapists using them too, they should be used to open dialogue with a client about suicidal thinking and to provide broad, contextual understanding only, rather than to assess risk (as detailed in the NICE guidance).

This wider context can contain important information. For example, research by the Kent and Medway Suicide Prevention Team found that approximately 30% of all suspected suicides between January 2019 and January 2022 'have been impacted by domestic abuse (either as a victim, perpetrator or as a young person affected by the abuse' (Kent and Medway, 2022). Such information is critical in understanding a client's context and its potential for risk, but still needs to be explored clearly and openly with the client directly.

NICE further states that:

Part of the NICE recommendation is that every psychosocial assessment should lead to a risk formulation. Specifically, they define a mental health formulation as a 'collaborative process' (p 45), which can usefully include a safety plan.

While this guidance strongly challenges the current status quo of working with suicide risk in many settings, it is entirely consistent with the ethos of counselling and psychotherapy as a process rooted in dialogue and therapeutic exploration.

It is important to restate that while tools can provide useful information and can additionally help structure questions the practitioner might need to ask clients about their suicidal thoughts or intent, they do not, of themselves, have any reliable, predictive quality for individual risk.

As such, they can only open the door to a discussion about suicide. Therapeutic risk assessment involves building a strong therapeutic alliance through which honest and explicit conversations about suicide risk can take place. Knipe et al., (2022) further argue that interventions around suicide risk should be informed by clinical and/or therapeutic discussion directly with the client, and informed by community support and services. They further reinforce that all professionals – including counsellors and psychotherapists – have a crucial role to play in responding to suicide risk.

2.2 Protective factors

Protective factors can often provide a way forward for the client in thinking about how they can continue to take responsibility for their own wellbeing, where possible, and how they might develop additional support strategies. Table 2 identifies some of the possible protective factors.

It is important to keep in mind that such factors will be particular to the individual and those listed in Table 2 offer an example for information.

It is always critical for the practitioner to feel sufficiently confident to talk clearly and openly with their clients about risk, and how the client has kept themselves safe up to this point. What is critical here is that the evidence, good practice and the core ethos of counselling and psychotherapy all speak to the importance of talking with clients directly and clearly about the potential for suicide; asking about suicide will not put the thought into a client's mind, nor increase risk.

Table 1: Protective factors in suicide prevention
(Reeves, 2015)

- some capacity for emotional expression
- willingness to talk about thoughts and feelings
- informal support networks (e.g. friends, family)
- formal support networks (e.g. mental health support, counselling)
- involvement in interests and activities
- established successful coping strategies
- other key individuals the client is willing to talk to
- options for 'out of hours' support (e.g. at night/weekends)
- physical activity, such as exercise
- important and identified key attachment figures
- a collaboratively agreed keep-safe plan
- attending counselling
- quality of therapeutic engagement and the therapeutic alliance.

3 Recognising suicide risk

While clients will sometimes make explicit references to suicide, often such thoughts are expressed in other ways. For example, expressions such as 'I can't see the point any more', 'I'm too tired to carry on any more' or 'everyone would be better off if I were not here', may communicate suicidal thoughts of equal intensity as those of clients who state explicitly that they are thinking of killing themselves. Research tells us that when a client first references their suicidal thoughts in a session, it is likely to be implicitly, e.g. using metaphor, rather than explicitly (Reeves, et al. 2004). As such, the confidence of the practitioner to be willing to ask explicitly about suicidal ideas and risks is essential.

It can be difficult to know how best to respond to a client who you suspect might feel suicidal but has not explicitly stated it. Practitioners often fear that talking about suicide will 'put the thought into the client's mind', or might be experienced by the client as 'offensive or clumsy'. These understandable anxieties can often prevent practitioners from feeling sufficiently confident to talk about suicide explicitly; for example, by naming it if the client has not.

There is no evidence that asking clients whether they have suicidal thoughts will put the thought into their mind if it was not there before. There is, however, a great deal of evidence to suggest that being able to talk to clients about suicide is extremely important in providing a safe space for them to explore their feelings. Clients often describe a sense of relief at being able to talk about their suicidal feelings. However, some clients will not feel able to express their suicidal feelings at all, either implicitly or explicitly. Other clients may also feel suicidal but have no intention of acting on those feelings. Some clients say that knowing suicide is an option for them is sufficient to help them cope with distressing or overwhelming feelings. It is, therefore, important to ask clients about suicide routinely, even if there are no explicit signs of suicidal thoughts, plans or preparations. This is important even if you suspect that they may be feeling suicidal, even if, at that point, they do not feel able to explore it further.

How to embark on a clear and open discussion about suicide will be informed by several factors, such as: the setting in which the therapy takes place; the age, understanding or emotional capacity of the client; and the individual approach of the practitioner. Just asking clients whether they feel so low that they are considering taking their own lives can communicate to the client that the thought of suicide is something that the practitioner is able to hear. Clients can often perceive this as 'permission' to voice their most difficult feelings and thus begin to explore their suicidal thoughts as the therapeutic work progresses.

Additionally, exploring with clients how they can keep themselves safe or ways in which they are able to manage suicidal thoughts can help them reflect further on the meaning of their feelings. It is important for practitioners to think about how they might ask a client about suicide (depending on the individual circumstances of the client, or agency). However, good practice suggests asking clearly, openly and empathically, e.g. *'wonder how difficult things get for you? For example, are there times when you consider hurting yourself, or ending your life in response to how you feel?'*

4 Exploring suicidal thoughts as a means of assessment

Suicide risk assessment should focus more on exploration of risk of suicide including thoughts and ideas about suicide, individual predisposing factors, individual modifiable factors, individual future factors and individual strengths and protective factors. This exploration can help the client to make sense of their own thoughts and ideas, and how they can manage their situation to keep themselves safe. There is often insufficient emphasis in the literature on the importance of exploration, which remains at the heart of the relationship between a practitioner and client (Reeves, 2018). There is a risk that therapists instead often reflect back the client's experience rather than actively exploring it. A purely reflective approach risks confirming despair rather than restoring hope (Reeves et al., 2004).

Clients need help to explore the nature and severity of their suicidal thoughts and risks, as well as looking at ways in which they can manage their distress. Sometimes suicidal thoughts can be fleeting and general in nature, while for others suicide is a constant, intrusive idea. Talking more about and exploring suicidal feelings will begin to help clients, as well as practitioners, clarify how the thoughts are experienced and managed and can challenge the stigma that exists around suicide and suicidal feelings. Stigma and a fear of being judged are often key contributory factors as to why clients may be reluctant to talk openly about these feelings. Other reasons for lack of disclosure can include fear of being 'sectioned' under mental health legislation, not wanting to be stopped, thoughts not present at the time (due to changeability, and that often the time between ideation and action is short even with enduring suicidality).

When exploring suicide risk, practitioners need to consider the client's capacity or functional maturity to talk about their thoughts or feelings of suicide in an informed way. Where there are concerns that a client is unable to understand the implications of their decision-making about suicide, further assessment should be sought from a GP or mental health service. Expressing suicidal thoughts is generally in itself insufficient to justify breaking confidentiality against a client's expressed wishes.

Reeves and Bond (2021) provide a helpful summary of the specific factors that practitioners need to consider in such circumstances, including three primary scenarios:

- the client is competent to make their own decisions over treatment and to take control over their living or dying
- there is doubt about the individual's mental state and therefore their capacity to make decisions about suicide
- the client clearly lacks the capacity to understand the consequences of their potential actions and therefore may act impulsively and be unable to make use of the support of keep-safe plans.

Determining the 'capacity' or 'mental state' of a client is notoriously difficult and often only clarified with the involvement of specialist mental health services.

While counsellors and psychotherapists are not expected to undertake an in-depth assessment of an individual's mental state or capacity as might a psychiatrist, for example, in making judgments about the safety of the client and possible referral to a GP or mental health services, the practitioner needs to be able to demonstrate that they have carefully considered the client's right to autonomy and confidentiality against the risk of suicide presented in the session.

Practitioners may find Good Practice in Action Legal Resources 014 *Managing confidentiality*, 030 *Safeguarding vulnerable adults*, and 031 *Safeguarding children and young people* helpful. These can be found at www.bacp.co.uk/gpia.

5 Responding to suicide risk

It is important that when asking a client about their suicidal thoughts, particular attention is given to their current thoughts, any plans they might have, any preparations to act on those plans, and what the client considers to be those factors that might increase or reduce their risk. The therapist should remain curious about the client's thoughts and feelings about suicide, in the context of a therapeutic dialogue, and particularly how things might change for the client in terms of their risk.

A client's own coping strategies – the client's protective factors – remain one of the most significant resources in managing suicidal ideas. Asking clients how they have kept themselves alive and in what ways they have prevented themselves from acting on their suicidal thoughts might help to develop or reinforce future coping strategies. A client's unwillingness or inability to continue to identify and use such strategies might indicate that they are no longer able to keep themselves safe.

Discussing what support might be available to clients outside therapy is crucial. This might include family, friends or other sources of help such as other professionals or out-of-hours helplines.

Equally important is the client's willingness or ability to access such support when needed. If a client does not feel able to contact support at times when they have suicidal thoughts and impulses, it is necessary to help them consider factors that might make using such support more likely. If the client is not able to consider ways in which they could use support when suicidal feelings are most intense then concerns might be increased about their ongoing safety.

For therapists working with risk of suicide, it is good practice to use 'keep-safe plans' in their work.

These plans, collaboratively agreed with a client, provide the client with information that details their individual risk factors (to help the client recognise when they might be at greater risk), as well as their protective factors (specific things a client may be able to do to support themselves at times of crisis between sessions, including how to access additional help). Table 3 provides some questions that might helpfully shape a keep-safe plan for a client.

Table 2: Developing a collaborative keep-safe plan

A keep-safe plan will aim to:

- focus on the specific risk factors for the client (what makes suicide more likely)
- focus on the specific protective factors for the client (what makes suicide less likely)
- identify 'danger times' when risks might be greater, or harder to balance with protective factors
- provide a specific list of available support options, both informal and formal (including telephone/email contact details)
- be written collaboratively with the client (a client's unwillingness, or inability to work collaboratively on such a plan may indicate a level of risk that needs further attention)
- encourage a client's sense of 'ownership' and control of the plan, i.e. it is their plan to have a copy of and take away
- be presented in a way the client can understand when away from the session
- be reviewed weekly (or regularly)
- be inclusive of (and perhaps shared with) others, wherever possible and appropriate
- be responsive to the client's age and level of understanding.

It is possible to fully explore suicide risk with clients both in face-to-face and in online settings, including talking about and establishing a keep-safe plan.

An example of developing a keep-safe plan (as well as asking questions about suicide) can be found at: www.bacp.co.uk/cpd/exploring-suicidal-risk-with-clients-gpiael2.

Risk assessment is an inexact science: it is impossible to predict with any certainty how an individual will react to difficult or changing circumstances. Practitioners should not think they have to achieve the impossible and predict the future. However, by exploring the client's suicidal feelings and thoughts and how they might react to them in detail with clients, the practitioner is better placed to work with them in thinking about future safety. All decisions should, wherever possible, be collaboratively agreed with the client and be acted on in the context of the client's explicit, written consent. That might include, in some circumstances, continuing to work within the boundaries of the confidential therapeutic relationship or discussing concerns with other people with or without the client's permission.

Where the therapist and client agree that to continue to work together would be a preferred option, it should not be undertaken instead of a referral on to specialist services. It is important to remember that a network of support is best likely to help keep the client safe. Should a client refuse the therapist's referral to another service in the light of concerns about the client's safety, this might indicate a 'red flag' that the risk can no longer be safely contained in the therapy relationship. Stopped therapy can increase the suicide risk for clients if the client wishes to continue and experiences therapy as an important protective factor. However, it is important not to isolate the therapy; better to ensure therapy is part of a client's support and not the only thing they feel they can rely on.

Deciding to disclose information about concern to a third party, such as a General Practitioner (GP) or crisis team remains one of the most difficult decisions for practitioners. An important overriding consideration here is that, wherever possible and practical, practitioners should not go against a client's known wishes, even with regard to suicide, in isolation. That is, such decisions need to be made collaboratively, with a supervisor, manager or senior practitioner, for example.

Another person's perspective can be vital in ensuring such decisions are made in the best interests of the client, rather than in response to practitioner anxiety (see GPiA LR: 014 and 065).

Careful contracting from the outset, in which the exceptions to confidentiality are clarified, together with an explanation of what action may be taken in these circumstances, may avoid potential problems with disclosure (see Good Practice in Action 039 Commonly Asked Questions: *Making the contract* and 055 Fact Sheet: *Making the contract in the context of the counselling professions* and Good Practice in Action 044 Fact Sheet: *Ethical decision making* for more information). It is important to agree the parameters of confidentiality with the client so that there is transparency and the circumstances in which a practitioner may be obliged to disclose to another party are understood.

However, if the practitioner feels that despite talking things through, the client remains at immediate risk to themselves and is unwilling or unable to consent to the disclosure of information to a third party, it is important that the practitioner acts on their concerns quickly and appropriately. There are several possible ways in which a practitioner can respond.

It might be appropriate to contact the client's GP to express specific concerns about the nature of the suicide risk and to discuss how to respond to the client. In some regions it might be possible to contact a mental health crisis team who could consider a range of responses with the practitioner and the client.

Some practitioners and clients agree the name of a person the client would like to be contacted in the event of an emergency, at the beginning of therapy, and often refer to this person as a 'trusted other' in keep-safe plans. However, if this named person is a friend or relative, the practitioner still needs to make sure they have enough information about a client to contact a professional for additional specialist support, if required.

6 Working with risk online

Through the development of new technologies and practice changes due to the Covid pandemic, much more therapy has moved to an online environment. As such, much in the same way that suicide risk may be present in face-to-face settings, it will be in online sessions too. (See Good Practice in Action 047 *Working online in the counselling professions*.) While there are factors to consider for working safely online, the key messages outlined in this Fact Sheet are equally applicable. That is, practitioners should not use risk assessment tools, delivered via online means, to determine the extent of suicide risk. Rather, they should be prepared and willing to ask clients open and clear questions about suicide, providing a safe therapeutic space for them to feel able to talk about their thoughts and feelings.

The disinhibition effect that can sometimes be present in online interactions – where people may be more willing to openly share emotions, feelings or reactions sooner than in face-to-face interactions – may also include disclosing suicidal thoughts.

As with face-to-face work, practitioners need to ensure that safe boundaries are in place to help work effectively with suicidal clients, who may be geographically some distance away. This can pose particular challenges where the practitioner might not be as familiar with local mental health or support services.

The following points can help support safe practice online with suicidal clients:

- Ensure clear information, including about referral options, such as GP information, is collected before therapy commences
- Ensure the client is clear as to the limitations of confidentiality offered with respect to suicide risk
- Always be willing to talk openly about suicidal thoughts and feelings with clients and do not rely on assessment tools to provide accurate information
- Pay attention to the space in which a client is accessing sessions: can they talk freely about their suicidal thoughts and, if not, what additional safeguards might be put in place, e.g. additional email contact
- Work with 'keep-safe plans', either through the use of screen-sharing (which most platforms offer) or making use of the online 'keep-safe plans' that are freely available
- Make available to clients information about additional national support services they can access at times of difficulty and, if possible and with some research, services local to the client.

It is entirely possible to work effectively with suicide risk when offering online counselling if supportive structures are put in place at the commencement of any therapy. BACP's Online and phone therapy (OPT) competence framework includes competences for assessing and managing risk when working remotely with clients. See www.bacp.co.uk/events-and-resources/ethics-and-standards/competences-and-curricula/online-and-phone-therapy.

7 Confidentiality and records

When working with suicidal clients, practitioners will adopt different approaches that respect the complexities of the particular client and therapeutic relationship. One of the most significant anxieties for practitioners when facing suicide risk is whether to disclose information and share their concerns with another person, perhaps the client's GP. Given the importance that confidentiality has in developing and maintaining a therapeutic relationship, it is essential that the original contract includes an agreement and an understanding of situations in which information may be disclosed.

The *Ethical Framework for the Counselling Professions* emphasises the importance of confidentiality, committing members to 'protecting client confidentiality and privacy' (Commitment, point 3b). Disclosing information without the explicit consent of the client therefore requires consideration and practitioners should be able to clearly state and document in the client's record the rationale for their actions in such situations.

Although the *Ethical Framework for the Counselling Professions* does not specifically require the practitioner to break confidentiality with a client who talks about suicide, it does advocate informing clients that confidentiality may be limited to protect them from serious harm, and also recognises the importance of the practitioner's judgment about the balance between potential harm to the client of either disclosing information or maintaining confidentiality (Good Practice, point 55d).

This is a difficult balance for practitioners to achieve. Practitioners must make decisions in the context of organisational policy and the contract agreed with the client at the outset of their work, about how to best safeguard the client's wellbeing in the face of suicide potential; these issues are more fully discussed by Jenkins (2002).

Given that it is extremely difficult to know with any accuracy whether clients will act on their suicidal thoughts and feelings, practitioners must articulate clearly to their clients, supervisors, line managers and in any notes they may keep, the specific reasons for their actions.

These may include:

- the reasons why the practitioner believed disclosure was in their client's best interests
- what the purpose of disclosure was, e.g. referral for psychiatric assessment
- why it was not possible to gain client consent. This may be because the client was unable to give their informed consent at that point due to the level of their emotional and/or physical distress.

The *Ethical Framework for the Counselling Professions* notes the importance of practitioners 'keeping accurate and appropriate records' (Commitment, point 2e) of work undertaken. Many statutory agencies, such as those in health and social care, require comprehensive notes to be maintained. Practitioners in private practice, however, may consider what 'accurate and appropriate records' mean within their own context and practice.

In so doing they need to be able to justify this decision. Any records kept must comply with the Data Protection Act 1998 and The UK General Data Protection Regulation (see Good Practice in Action 105 Legal Resource). The Information Commissioner's Office has a downloadable guide that practitioners may find helpful at: <https://ico.org.uk/for-organisations/guide-to-data-protection>. The process of making, sharing and storing notes needs to be both transparent and understood by the client, and when notes are made, they should be suitable for the purpose for which they are being written.

A more detailed discussion of record keeping can be found in Bond and Mitchels (2014).

There are also several very useful Good Practice in Action resources on various aspects of confidentiality and record-keeping and these can be found at: www.bacp.co.uk/gpia.

When working with client at risk of suicide, notes can provide an important record of interventions made and the rationale for those interventions. For example, it can be helpful for the practitioner to record the following:

- specifically how the client expressed their suicidal thoughts or intent
- specifically how the practitioner responded to the expressed risk of suicide – what they said and what they did
- the factors that suggested that suicide was more likely
- the factors that suggested that suicide was less likely
- a written risk formulation, setting out individual predisposing, modifiable, future and safety and protective factors
- a copy of the written keep-safe plan that was negotiated and shared with the client
- the outcome of the session, e.g. any consultation with third parties such as a supervisor, whether confidentiality was maintained and whether the client was in agreement with the outcome. These pointers may help practitioners to structure any notes following a session with a client at risk of suicide. However, notes will also reflect the individuality of the practitioner and organisational requirements.

8 Supervision and self-care

Practitioner self-care is a fundamental part of a practitioner's professional duty and is clearly outlined in the *Ethical Framework for the Counselling Professions* and further supported by Good Practice in Action 088 Fact Sheet: *Self-care for the counselling professions* and a number of other Good Practice in Action resources for supervision and fitness to practise (www.bacp.co.uk/gpia). Research suggests that there may be a link between working with suicidal clients and vicarious trauma (Fox and Cooper, 1998).

Fox and Cooper identify several factors that are important for the practitioner to consider when reflecting on how working with clients at risk of suicide affects them, including:

- guilt over your perceived failure to recognise warning signs
- fear of your incompetence or irresponsibility
- shame from a sense of perceived 'failure'
- fear of litigation
- fear of blame by the client's family/friends and colleagues.

All these factors can inhibit the strategies that might usually be used to support practice. For example, the fear of blame could inhibit the use of peer support from colleagues. It is important that practitioners consider ways in which they need to support themselves. For practitioners working within a team setting, the discussion might include how the team can support ongoing work and how they might respond in the event of a client death. All practitioners can helpfully consider factors that might inhibit them from accessing usual support systems and ways of changing this.

The role of supervision in working with all clients, and particularly clients at risk of suicide, is central (Reeves, 2015). Practitioners will often look towards their supervisors for support and encouragement in addition to guidance.

When possible, consultation with a supervisor in the event of immediate concern over a client can be invaluable in helping the practitioner to remain client-centred rather than anxiety-driven.

It is helpful to talk through hypothetical situations with a supervisor before those situations arise in practice, and to keep suicide on the supervision agenda. Such discussions can include mutual expectations, thoughts and feelings in addition to important practical issues, and contracting considerations, which might include when and how a supervisor would expect to be contacted outside of usual supervision sessions.

Personal views about suicide, influenced by religious, cultural, philosophical or ethical positions, can influence our responses to suicidal clients. It is important that we provide time to reflect on our own views and feelings and how our responses to clients relate to our own position.

Supervision also allows an important space for practitioners to talk about their competence in working with risk. Ideally, clients will be assessed as suitable for working with a trainee prior to the commencement of counselling by a qualified practitioner, and where issues concerning suicide risk have been identified the client would be referred to a more experienced counsellor. However, as suicide risk may not always present or be apparent in the initial assessment, trainees may find themselves in a situation with a client where their limits of competence are challenged and they feel out of their depth, (Working to professional standards, Good Practice, point 13), it is therefore important that trainee placements have good support structures in place, with robust arrangements for supervision, clear safeguarding procedures and referral pathways, for example.

Competence is not solely the focus for trainees however, and experienced practitioners too will have to reflect on their competence, which can be influenced not only by a lack of experience, but also direct experience. For example, the death of a client through suicide might impact on a practitioner such that they feel unable to manage working with risk for a while.

It is critically important that we can all be open about our capacity to work with different client presentations, and with suicide risk specifically, at different times throughout our working life, to ensure we are best able to meet our client's needs.

Summary

The relationship practitioners build with clients can be invaluable when distress is so great that clients are considering suicide. It is essential, however, that the practitioner takes active steps to ensure that the therapeutic process is supported.

The fear of litigation and of 'getting it wrong' can be extremely powerful – it is an ethical imperative that decisions regarding the safety and confidentiality of the client relationship are taken for the wellbeing of the client.

The areas considered here can help provide ways of supporting both practice and the practitioner. Ultimately, it is impossible to know with any certainty how a client might react to life events. However, it is possible for professional judgments to be based on informed knowledge, which in turn can provide the safest environment for such difficult issues to be explored. It is not possible to predict suicide with any accuracy. However, a therapeutic approach to risk assessment, risk formulation and safety planning can enable client and practitioner to work together to support both safety and therapeutic work.

About the author

Andrew Reeves is a BACP senior accredited counsellor/psychotherapist, Registered Social Worker, an EMCC senior accredited coach and accredited coach supervisor, working as a supervisor of practice and research, is a Professor of Counselling Professions and Mental Health and author. He has many years' experience of working in mental health settings and in an emergency mental health crisis team and has undertaken extensive research into suicide risk assessment for practitioners. He has written extensively on working with risk.

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References

BACP (2018) *Ethical framework for the counselling professions*. Lutterworth: BACP.

BACP (2017) (updated 2018) Good Practice in Action 044 Fact Sheet: *Ethical decision making in the context of the counselling professions*, (Content Ed. Gabriel, L.). Lutterworth: BACP.

BACP (2015) (updated 2020) Good Practice in Action 057 Legal Resource: *Suicide in the context of the counselling professions in England and Wales*, (Content Ed. Mitchels, B.). Lutterworth: BACP.

BACP (2018) (updated 2020) 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* (Content Ed. Mitchels, B.). Lutterworth: BACP.

Bond, T., Mitchels, B. (2014) *Confidentiality and record keeping in counselling and psychotherapy* (2nd edition). London: Sage.

Daines, B., Gask, L., Usherwood, T. (1997) *Medical and psychiatric issues for practitioners*. London: Sage.

DfH (2022) www.gov.uk/government/news/men-urged-to-talk-about-mental-health-to-prevent-suicide (accessed July 2024).

DfH (2023). *Suicide Prevention Strategy for England: 2023-2028*. Available at: www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028 (accessed July 2024).

DfH Northern Ireland (2012) *Protect Life 2: Suicide Prevention Strategy* Available at: www.health-ni.gov.uk/protectlife2 (accessed July 2024).

Fox, R., Cooper, M. (1998) The effects of suicide on the private practitioner: A professional and personal perspective. *Clinical Social Work Journal* 26: 143-57.

Healthcare Quality Improvement Partnership (2018) HQIP (2018) The assessment of clinical risk in mental health services. Manchester: University of Manchester. www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf.

HMG/Department of Health (2012) *Suicide prevention strategy for England* London: HMG. Available at www.gov.uk/government/publications/suicide-prevention-strategy-for-england (accessed July 2024).

Jenkins, P. (2002) *Legal issues in therapy and psychotherapy*. London: Sage.

Kent and Medway Suicide Prevention Team. (2022). *Highlighting the link between domestic abuse and suicide* – Available at: <https://nspa.org.uk/resource/link-domestic-abuse-and-suicide> (accessed July 2024).

Knipe, D., Padmanathan, P., Newton-Howes, G., Chan, L F. and Kapur, N. (2022) Suicide and self-harm. *The Lancet*. 399 (10338) pp 1903-1916. DOI: [https://doi.org/10.1016/S0140-6736\(22\)00173-8](https://doi.org/10.1016/S0140-6736(22)00173-8).

National Assembly for Wales (2022) *Talk to me 2 – Suicide and self harm prevention strategy for Wales 2015–22*. Available at: www.gov.wales/suicide-and-self-harm-prevention-strategy-2015-2020 (accessed July 2024).

National Institute for Health and Care Excellence (2022) *Nice guideline 225* www.nice.org.uk/guidance/ng225/chapter/Recommendations.

Reeves, A. and Bond, T. (2021) *Standards and ethics for therapy in action* (5th edition). London: Sage.

Reeves, A., Mintz, R. (2001) *The experience of practitioners who work with suicidal clients: an exploratory study*. *Counselling & Psychotherapy Research* 1(3): 172-176.

Reeves, A., Bowl, R., Wheeler, S., Guthrie, E. (2004) The hardest words: exploring the dialogue of suicide in the counselling process – a discourse analysis. *Counselling & Psychotherapy Research* 4(1): 62-71.

Reeves, A. (2015) *Working with risk in counselling and psychotherapy*. London: Sage.

Reeves, A. (2017) In a search for meaning: Challenging the accepted know-how of working with suicide risk. *British Journal of Guidance and Counselling*, 45(5): 606-609.

Richards, B.M. (2000) Impact upon therapy and the practitioner when working with suicidal patients: some transference and countertransference aspects. *British Journal of Guidance and Counselling* 28: 325-37.

Royal College of Psychiatrists (2020) *Self-Harm and Suicide in Adults: Final Report of the Patient Safety Group* – CR229. London, UK: Royal College of Psychiatrists.

Scottish Government (2022) *Scottish Government: suicide prevention strategy Creating Hope Together*. Available at: www.gov.scot/news/suicide-prevention-strategy-creating-hope-together (accessed July 2024).

Scupham, S., Goss, S.P. (2020) Working with suicidal clients: Psychotherapists and allied professionals speak about their experiences. *Counselling and Psychotherapy Research*. 20: 525-534. <https://doi.org/10.1002/capr.12288>.