Good Practice in Action 042

Fact Sheet Resource

Working with suicidal clients

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British Association for
Counselling & Psychotherapy

Working with suicidal clients

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Context

This document is one of a suite of resources prepared by BACP to enable members to engage with the BACP *Ethical Framework for the Counselling Professions* (BACP, 2016) in respect of mental health.

Using fact sheet resources

BACP Good Practice in Action resources are a new series of publications that are free to BACP members to download. It is hoped these 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.

BACP members have a contractual commitment to work in accordance with the current *Ethical Framework for the Counselling Professions*. The Good Practice in Action Resources are not contractually binding on members, but are intended to support practitioners by providing general information on principles and policy applicable at the time of publication, in the context of the core ethical principles, values and personal moral qualities of the BACP.

Specific issues in practice will vary depending on clients, particular models of working, the context of the work and the kind of therapeutic intervention provided. As specific issues arising from work with clients are often complex, BACP always recommends discussion of practice dilemmas with a supervisor and/or consulting a suitably qualified and experienced legal or other relevant practitioner.

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.

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1 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
- risk factors
- recognising suicide risk
- assessing and exploring risk
- responding to suicide risk
- confidentiality and records
- supervision and self-care.

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2 Introduction

Clients presenting in therapy with suicidal thoughts or plans can be challenging for even the most experienced practitioner. Understanding the experience of feeling suicidal for the client, 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 boundaries 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 is suicidal, including fear, anger, 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 (Rudd, et al. 1999). 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 have been decreasing over the last two decades, recent statistics show an increase in suicide rates once again and, for particular groups such as males, suicide remains one of the mains causes of death (DoH, 2015)

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3 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, 2012; National Assembly for Wales, 2015; Northern Ireland Assembly, 2012; 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 the BACP *Ethical Framework for the Counselling Professions* (2016). 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 should a client present at high 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 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).

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4 Risk and protective factors

4.1 Risk factors

Practitioners need to be aware of factors that might suggest their client is in a high-risk category; so-called risk factors (factors that might make suicide *more* likely). As with any client, it is impossible to accurately predict what an individual will do or how they might respond to situations in their lives. Table 1 lists specific demographic factors and population groups that are at higher risk of suicide. Knowledge of risk factors does not in itself help us know whether a suicidal client is likely to act on their thoughts or feelings. However, this knowledge can provide a means by which we can 'structure' our own thinking about client risk and inform the dialogue that then needs to take place with the client.

Factors associated with higher suicide risk can provide important contextual information for practitioners when responding to suicidal clients. Such information does not provide diagnostic information about clients, nor does it tell us specifically how a suicidal individual will respond to their changing situation. It does, however, provide knowledge and understanding about suicide trends within specific population groups. For example, knowing that gender, age and social relationships are significantly correlated to higher suicide risk might be helpful to a practitioner working with a young, socially isolated, male client expressing suicidal thoughts. Likewise, research on risk factors informs many of the risk assessment tools developed by agencies to help practitioners identify the potential for suicide in their clients. These tools can provide useful information and can additionally help structure questions the practitioner might need to ask clients about their suicidal thoughts, but do not, of themselves, have a strong predictive quality for individual risk. They support risk assessment, but do not replace the dialogue with the client.

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Table 1. Demographic and other factors associated with higher suicide risk

- gender, males generally present with greater risk across different ages
- age, males aged 15-50 and over 75
- relationships, single, widowed, divorced/separated
- social isolation
- mental health diagnosis, including:
  - depression
  - schizophrenia
  - alcohol/drug misuse
  - homelessness
  - paranoia
  - mood disorders
  - psychosis
  - affective disorders
  - lack of affective control
  - anxiety/ panic disorders
  - PTSD
- occupational factors e.g. unemployed/retired
- personality disorders, e.g. sociopathy, aggression
- history of child sexual abuse/child physical abuse/ adult sexual assault
- specific plan formulated
- prior suicide attempts/family history of suicide or suicide attempts
- physical illness and ie biochemical hormonal other medical factors changes.

(Reeves, 2015)

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4.2 Protective factors

Much of the literature that addresses work with suicide risk focuses on risk factors, whereas protective factors (those factors that might make suicide *less* likely) are equally important. 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 key protective factors. However, it is importat to keep in mind that, like risk factors, many will be particular to the individual. 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 supported themselves up to this point.

Table 2: Protective factors in suicide prevention

- 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 crisis plan
- attending counselling
- quality of therapeutic engagement and the therapeutic alliance.

Reeves, 2015

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5 Recognising suicide risk

While clients will occasionally 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 the 'suicide question' 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 '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. 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 if you suspect that they may be feeling suicidal, even if at that point they do not feel able to explore it further.

The wording of such questions is important and needs to be treated sensitively. Much will depend upon 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 are able to 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, best practice suggests asking clearly, openly and empathically, eg *'I 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?'*

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6 Assessing and exploring risk

While suicide risk *assessment* (identifying and balancing risk and protective factors) is important, the work of practitioners should also focus on suicide risk *exploration* (enabling the client to make their own sense of the meaning of their thoughts, to help them reflect on ways in which they may support themselves accordingly). 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.

Suicidal clients need help to explore the nature and severity of their suicidal thoughts, 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 suicidal feelings will begin to help clients, as well as practitioners, clarify how the thoughts are experienced and managed.

When exploring suicide risk, practitioners need to consider whether the client has sufficient capacity or intellectual maturity to make a decision to end their own life. Expressing suicidal thoughts is generally in itself insufficient to justify breaking confidentiality against a client's expressed wishes. Bond (2009) provides 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 is therefore at high risk of suicide.

Determining the 'capacity' or 'mental state' of a client is notoriously difficult and often only clarified with the involvement of specialist mental health services. Practitioners are not expected to undertake an in-depth assessment of an individual's mental state or capacity. However, in making judgements 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 *Breaching Confidentiality*, 030 *Safeguarding Vulnerable Adults*, and 031 *Safeguarding Children and Young People* helpful. These can be found at www.bacp.co.uk/ethics/newGPG.php.

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7 Responding to suicide risk

There are a number of helpful ways in which a practitioner can explore suicide with a client. Asking clients to rate the intensity of their suicidal thoughts can be useful. Offering a 0–10 scale (where 0 equals no intention to act and 10 equals an immediate intention to act) helps in the process of understanding the immediacy of risk. If the subjective score is high, ask the client whether they have planned how they might kill themselves or consider whether the risk is from a more spontaneous or impulsive act. Where the risk of suicide is from an impulsive act, help clients identify how or whether they feel able to resist such impulses, perhaps by talking through specific scenarios.

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 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 suicidal 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 of higher risk 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.

Some practitioners use 'crisis plans', or '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 crisis plan for a client.

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Table 3: Developing a collaborative crisis plan

A crisis 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, ie 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 level of age and understanding.

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 discussing their 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 continuing to work within the boundaries of the confidential therapeutic relationship or discussing concerns with other people with or without the client's permission.

Making a decision to disclose information about concern to a third party 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.

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Careful contracting from the outset, in which the exceptions to confidentiality are clarified, together with an explanation of what action may be made 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* 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 a number of 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. 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.

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8 Confidentiality and records

When working with suicidal clients practitioners will adopt different approaches that reflect 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 the rationale for their actions in such situations. The *Ethical Framework for the Counselling Professions* does not require the practitioner to break confidentiality with a client who is suspected of being at a high risk of suicide, but instead recognises the importance of the practitioner's judgement about the balance between potential harm to the client of either disclosing information or maintaining confidentiality.

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 best to safeguard the client's wellbeing in the face of suicide potential; these issues are more fully discussed by Jenkins (2002). Daines, et al. (1997), offer three factors that may be important in determining actions:

- whether the client's suicide was foreseeable
- whether, if the suicide risk was known or should have been inferred by the practitioner, the practitioner took appropriate precautionary measures
- whether the practitioner offered help in a reliable and dependable way.

Given that it is always impossible to know accurately whether clients will act on their suicidal thoughts, 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.

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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' means 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. The Information Commissioner's Office has a downloadable guide that readers may find helpful at: https://ico.org.uk/for-organisations/guide-to-data-protection/. The process for the making, sharing and storing of 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) and further good practice resources are being developed.

When working with suicidal clients, 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
- the outcome of the session, eg any consultation with third parties such as a supervisor, whether confidentiality was maintained or not and whether the client was in agreement with the outcome.

These pointers may help practitioners to structure any notes following a session with a suicidal client. However, notes will also reflect the individuality of the practitioner and organisational requirements.

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9 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 a number of good practice resources for supervision (www.bacp.co.uk/ethics/newGPG.php). 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 suicidal clients affects them, including:

- guilt over one's perceived failure to recognise warning signs
- fear of one's 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 suicidal clients, 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.

Contracting considerations 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.

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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 judgements to be based on informed knowledge, which in turn can provide the safest environment for such difficult issues to be explored.

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About the author

Andrew Reeves authored the content of this resource. He is a BACP Senor Accredited Counsellor/Psychotherapist and works as a supervisor (of practice and research), senior lecturer 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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BACP (2015) *Ethical framework for the counselling professions*. Lutterworth: BACP.

Bond, T. (2009) *Standards and ethics for therapy in action* (3rd edition). London: Sage Publications.

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 Publications.

Department of Health (2015) *Suicides in the United Kingdom: 2013 registrations.* London: Office for National Statistics. Available at www.ons.gov.uk/ons/dcp171778_395145.pdf (accessed 20 January 2016).

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.

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 20 January 2016).

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

National Assembly for Wales (2015) *Talk to me 2 – Suicide and self harm prevention strategy for Wales 2015-20*. Available at www.bing.com/search?q=talk+2+me+wales+suicide&src=IE-TopResult&FORM=IETR02&conversationid (accessed 20 January 2016).

Northern Ireland Assembly (2012) *Suicide prevention/protect life strategy.* Available at www.niassembly.gov.uk/assembly-business/official-report/committee-minutes-of-evidence/session-2011-2012/may-2012/suicide-preventionprotect-life-strategy/ (accessed 20 January 2016).

Reeves, A., Mintz, R. (2001) *The experience of practitioners who work with suicidal clients: an exploratory study.* Counselling and Psychotherapy Research Journal 2: 37–42.

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 and Psychotherapy Research* 4(1): 62–71.

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

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.

Rudd, M.D., Jobes, D.A., Joiner, T.E., King, C.A. (1999) *The outpatient treatment of suicidality: An integration of science and recognition of its limitations.* Professional Psychology – Research and Practice 30: 437–46.

Scottish Government (2013) *Scottish Government: suicide prevention strategy 2013 – 2016.* Available at www.gov.scot/Publications/2013/12/7616 (accessed 20 January 2016).