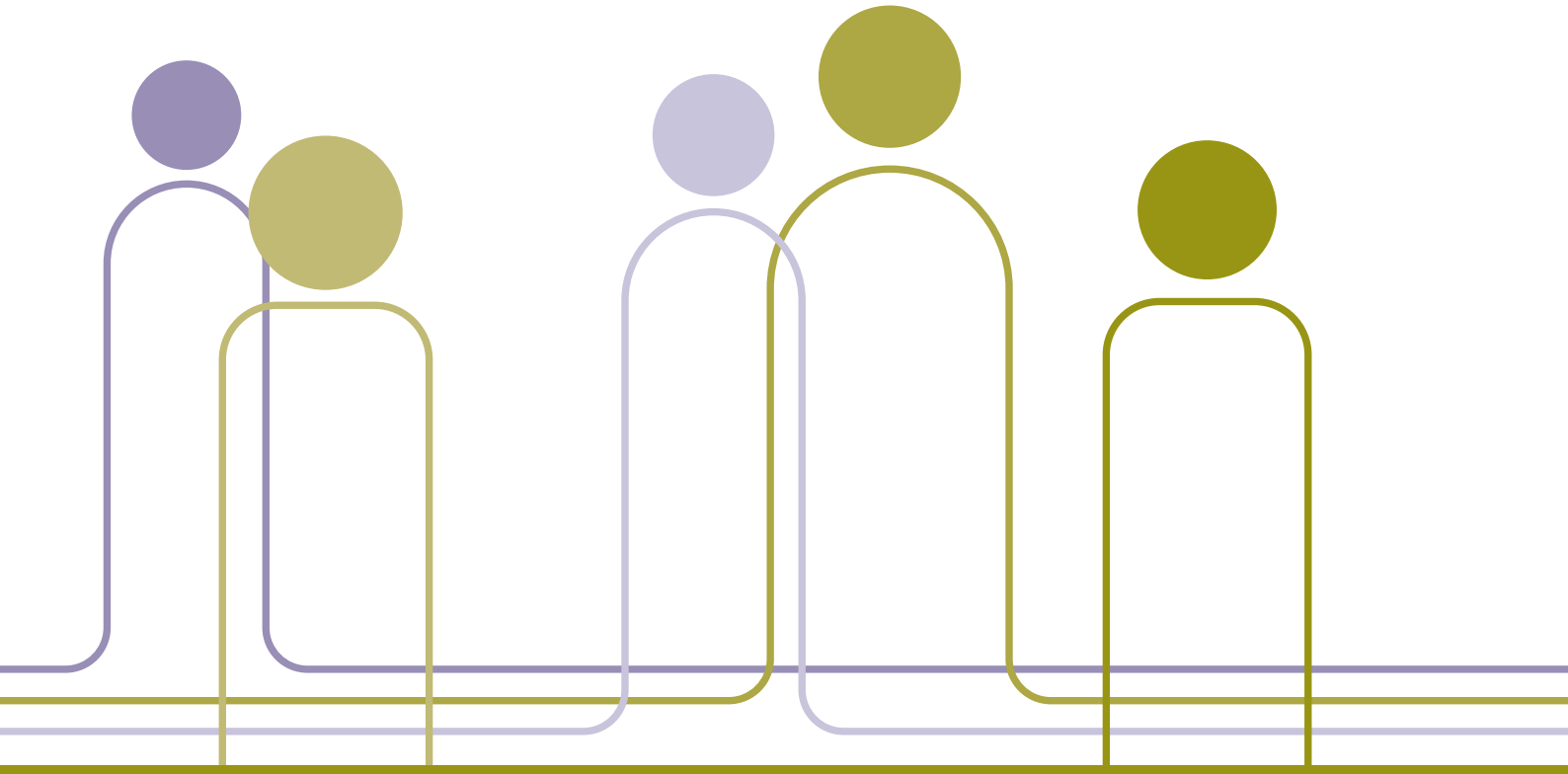
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006

Working with risk within the counselling professions



Fact sheet

Ethics in Practice

Ethics in Practice 006
Fact Sheet

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Using Fact Sheet resources

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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 terms 'practitioner' and 'counselling related services' are used generically in a wider sense, to include the practice of counselling, psychotherapy, coaching and pastoral care. The terms 'therapist' or 'counsellor' are used to refer to those trained specifically as psychotherapists and counsellors.

1 Introduction

Working with suicide risk in therapy can be one of the most demanding challenges faced in practice. Whether as newly qualified or as highly experienced practitioners, it's common to experience fear, anxiety, or self-doubt when navigating these conversations (Scupham and Goss, 2020). It is not uncommon for clients to bring suicidal thoughts or feelings into therapy and, for some, therapy may be the first safe space they have found to share them; this is not an uncommon phenomenon. It is important that responses are clear, compassionate, professional and, where possible, collaborative.

Practitioners can often grapple with difficult decisions about risk, safety, and confidentiality. These decisions cannot be made through checklists or flowcharts, but rather they require judgment, relational sensitivity, and emotional presence. Decisions are not best in isolation but, rather, with an ability on behalf of the practitioner to engage openly and consistently with clients about suicide, and with others too when required (and where possible permissioned). It is important to remember working with suicide risk is not an objective process of simply balancing information, but rather an exploration of suicidal thoughts directly with the client.

This fact sheet will consider working with suicidal clients, including setting and important policy and evidence-informed context for work, before then considering particular aspects of practice critical for ethical and appropriate work with clients at risk, including the importance of the contract, of exploring thoughts openly and directly with the client, drawing on the resources of supervision, ensuring a clear rationale for decisions made and, finally, the importance of self-care.

2 Understanding suicide and its context

2.1 Defining suicide

Suicide refers to the likelihood that a person may attempt or complete suicide through an action of ending their own life. It involves a complex interplay of thoughts, emotions, behaviours, and contextual influences. It is important to recognise that suicide risk is fluid and can shift rapidly; it is not always marked by overt or obvious behaviours. All therapy in identifying and responding to suicide must be relational and embedded in a collaborative therapeutic process, wherever possible and practical.

Therapists are not expected to diagnose suicidal thinking, nor use risk assessment tools to predict future behaviour, but rather to explore meaning and to ensure a client's risk and safety are appropriately responded to in a timely manner. The meaning of suicide for individual clients will differ greatly based on their personal, psychological and social circumstances, as well as cultural factors. In thinking about definitions, it is important to try to understand what suicide represents for the client themselves.

2.2 What does good practice tell us?

Good practice maintains a position that suicide prevention is a responsibility for us all, regardless of working context, with a commitment to honesty, transparency, and client wellbeing. The *Ethical Framework* places emphasis on building trust, creating clarity around boundaries, and ensuring appropriate support through supervision. This means engaging directly and empathetically with a client's suicidal feelings, rather than relying on predictive measures.

Practising ethically includes practitioners attending to their own competence to engage with a client's capacity to work in therapy, to contract appropriately to support good practice around suicide risk, to be aware of any working practices or procedures informing therapy, and to be prepared to act in the event of concern. Good practice additionally requires maintaining accurate records to capture a rationale for good practice and decisions made, as well as being accountable for those actions and decisions.

2.3 What does the evidence say?

The UK 'four nations' (England, Scotland, Wales and Northern Ireland) have each published guidelines for working with suicide risk as part of a commitment to suicide reduction. It is important to read such guidelines, relevant to the geographical region in which you work (DoH, 2023; DoH, 2025; National Assembly for Wales, 2025; Northern Ireland Assembly, 2023; Scottish Government, 2013).

It is additionally important to move away from prediction and towards meaningful engagement. The NICE guidance (NICE, 2022; NG225) explicitly cautions against the use of risk assessment tools for determining treatment decisions or predicting suicide:

- 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).

Instead, research clearly states that therapy should centre on direct dialogue with the client. Suicide risk should be approached as a therapeutic concern, rooted in exploration, understanding, and holding the person's experience in a way that can foster safety and hope. It is the context and the conversation that matter, not categorisation.

2.4 The dangers of 'risk factors'

The evidence consistently tells us that suicide cannot be accurately predicted.

The temptation of certainty can sometimes lead even the most reflective practitioner into wanting to categorise risk into low, medium and high groups using risk assessment tools.

However, such groupings often obscure more than they reveal: many individuals who have died by suicide were previously assessed as low risk, 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' using risk assessment tools (HQIP, 2018).

The evidence strongly shows that even the most sophisticated tools have little predictive value for individual cases. While evidence also highlights that certain groups are statistically more at risk, such as men under the age of 60, LGBTQ+ individuals, people from ethnic minorities, and those with a history of trauma or abuse, statistical likelihood should never replace individual understanding. The relationship with the client, and a willingness and ability to explore openly with them, remains the most effective resource.

2.5 What are 'protective factors'?

Protective factors are those aspects of a client's experiences, thinking and behaviour that might make suicide less likely, that can be explicitly explored with clients when thinking about their own safety, or in the development of keep-safe plans. As with risk factors, they must always be held in mind cautiously, in that they point towards factors that a client might be encouraged or supported to engage with, but do not in themselves guarantee safety. Table 1 provides a list of such factors:

Table 1: 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 keep-safe plan
- attending counselling
- quality of therapeutic engagement and the therapeutic alliance.

3 Working with suicide risk in counselling

3.1 How might we recognise suicide risk?

It is not uncommon for clients to not say outright that they are considering suicide. Often, metaphor or implied language is used, such as talking about feeling hopeless, worthless, or like a burden, or using phrases such as, 'I just want to go to sleep and not wake up', or 'I just want to get out of everyone's way'. The task is to remain alert to these cues and to be prepared to ask direct questions and explore these feelings and thoughts openly.

If the client is known, it may be possible to notice subtle shifts in mood, language, or engagement. A sudden sense of calm following a period of distress may indicate that the client has thoughts about ending their life. Equally, clients may joke about suicide or refer to it in passing. It is critical to remember also however, that clients may make no direct mention of it at all and for there to be no other noticeable changes. It is important that practitioners are always willing to open an exploration with clear questions about suicidal thinking.

Cultural, age, and gender factors also influence how suicide risk is communicated. Clients from some cultural backgrounds may not have a language for depression or suicide and may somatise their feelings or express distress through spiritual language. Cultural competence and a willingness to engage sensitively will support a fuller understanding of what is being communicated, being mindful of inclusivity in practice, including relational power dynamics that might lead to a client feeling less able to talk about their thoughts.

3.2 How should we explore suicide risk?

Asking directly, in a direct but compassionate way, if a client has thoughts of ending their life can create a turning point in the therapeutic relationship. Far from being harmful, such questions often bring a profound sense of relief.

Offering the client permission to talk about what they feared could not be said can begin to create a space where safety and risk can be discussed openly, along with future thoughts as to what steps might be taken.

Exploring suicide risk is not about ticking boxes, it is about creating space for a client to articulate their thoughts, feelings, and make sense of meaning. As part of an exploration of suicide risk, it is important to enquire into the nature and frequency of suicidal thoughts, whether any plans have been made, and how these thoughts are experienced. Are they fleeting? Are they constant? Do they bring comfort or fear?

It is also important to explore with clients what changes they notice that lead to their suicidal thoughts being more intense, or less so, or to go away completely. What is helping them stay alive? Who do they feel connected to? Do they notice any variations across the day, or week that might influence their thoughts? This exploration should be collaborative, as much as is possible, and may begin to uncover the meaning of the suicidal thoughts for the client. Finding meaning in suicidal thinking can often be a first, important step in safety planning.

It is also important to consider your client's developmental and emotional capacity to engage in such dialogue. For some clients, particularly those who are neurodivergent, have learning disabilities, or severe distress, or are a child or young person, this conversation may need to be paced carefully or involve support from other professionals. Knowing when to pause and when to proceed is part of therapeutic discernment. An inability to work collaboratively, or an unwillingness to work collaboratively around risk of suicide, might be a key indicator of the need to refer for more specialist support, perhaps to a General Practitioner (GP) or local crisis team.

Exploration should not only focus on risk, but also on agency: ask the client what they have done in the past to keep themselves safe, what has helped them survive difficult periods, and what coping strategies they trust. This builds on the client's own strengths and invites a potential re-engagement of their capacity to keep themselves safe.

3.3 What does 'risk formulation' mean?

Risk formulation is a structured way of understanding suicide risk in the context of a client's lived experience. Unlike risk prediction, which tries to calculate likelihood, formulation is about developing a nuanced picture that informs how working together can remain safe.

NICE define risk formulation as 'A collaborative process between the person who has self-harmed and a mental health professional that aims to summarise the person's current risks and difficulties and understand why they are happening in order to inform a treatment plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources' (NICE, 2022 p 42-3).

A strong formulation looks at four key dimensions: predisposing factors (such as trauma, chronic mental health difficulties, and early attachment issues); precipitating factors (current events that have triggered distress); perpetuating factors (what keeps the distress going); and protective factors (what supports the client to stay alive).

Formulation is a living, evolving understanding, which is built collaboratively and reviewed regularly. It can be helpful to capture in records, to discuss with a supervisor, and with the client.

3.4 Using keep-safe plans to respond to risk

Responses to suicide risk must be tailored to a client's circumstances, rooted within the therapeutic relationship and evolved through collaborative discussion. An effective tool to support clients is the development of a keep-safe plan. This is not something to impose, but something to build together through collaborative dialogue. The plan is important not only in terms of a resource the client may draw on between sessions, it additionally demonstrates that a full discussion has taken place (see 4.2 Demonstrating Ethical Practice) but, perhaps most importantly, it provides a structured dialogue through which the client might begin to have greater insight into their own thinking and feelings.

It is important to try to identify patterns that signal increased risk, such as difficult times of day or specific triggers, as well as what has helped them stay safe in the past, and who or what they might turn to in a crisis. Formal and informal supports should be named and accessible. Keep-safe plans need to be revisited regularly, updated to reflect change, and written in a way the client understands and feels they have ownership over.

A keep-safe plan might include actions as simple as texting a friend, taking a walk, avoiding alcohol, or using a crisis line. It should also contain specific details: names, numbers, times, and contingency steps. The more tangible the plan, the more likely it is to be used in moments of acute distress. Examples of having a discussion about keep-safe plans can be found at: www.bacp.co.uk/cpd-learning/exploring-suicidal-risk-with-clients-gpiael2.

Responding to risk also means knowing boundaries and not working in isolation. If in private practice, develop a network of contacts, including GPs, crisis teams, or trusted colleagues who can appropriately be consulted with. If in an organisation, make use of policies and escalation pathways. Always keep the client informed of intentions unless doing so would increase the risk.

3.5 What about urgent situations?

In some situations, it is important to act quickly, especially if it is believed the client is at immediate risk and not engaging with support, perhaps intending to leave your room or log off an online session and act on their thoughts. This could mean contacting emergency services or breaching confidentiality to protect life. It is critical that relevant information is captured in the contracting process, including GP name and contact number, or the local crisis services (including if working with clients remotely), for example.

Also, to document a rationale clearly, to act proportionately, and ensure support is available before, during, and after any such intervention. Explain to the client what is likely to happen and why, if possible, but do not delay if this is not possible. Acknowledge their fears, their sense of a loss of control, and their right to be heard. Even in crisis, collaboration remains a cornerstone of ethical care.

4 Working with risk online and internationally

4.1 Considerations when working online

Working online introduces additional considerations to suicide risk. The client's location may not be known during a session, e.g., they may be travelling or away from their usual location, or there may be limited knowledge of local services. Before online work begins, it is important to collect all necessary contact details, including emergency contacts, as well as the client's location at the time of each session. The contract must be clear about the limits of confidentiality and what might happen in a crisis, or in the event of the client leaving the session unexpectedly or of technological failure.

Clients may disclose suicidal thoughts more quickly in online sessions due to the reduced social pressure of screen-based interaction. Working online to co-create safety plans, and providing clients with information about support services, both national and local, can help maintain therapeutic depth and safety.

Attention needs to be given to the client's physical environment: are they alone; can they speak freely; are there interruptions or constraints, for example. These factors can affect the quality of the dialogue and an ability to respond safely to risk. It may be necessary to adapt your approach and discuss alternative communication methods outside session time, if appropriate and contracted.

4.2 Working with clients internationally

International work – where either the client or therapist are based outside the UK – introduces added complexity, particularly when suicide risk is present. It is critical to pay attention to the practical, legal, and ethical implications of the client's location.

Begin by clarifying, in the contract, where the client is geographically located during each session. This is not just a technicality as it may change an ability to respond in a crisis. It is not possible to assume that UK emergency processes, safeguarding laws, or referral pathways will apply.

Instead, it is important to develop a clear plan that considers the client's local services, including researching emergency numbers, mental health support organisations, or community-based networks in the client's region. It is also essential to ensure any work is legally compliant both in the UK and the region where the client is based, and that insurance continues to cover the work.

Be mindful of differing cultural attitudes to suicide, help-seeking, and therapy. What may be routine in the UK, such as contacting a GP, may not be possible or culturally appropriate elsewhere. Some countries may have more punitive laws regarding suicidal behaviour, or fewer protections for those in distress. This means any disclosure decisions must be weighed with extra care.

Ensure the client understands any potential limitations of any role and what can and cannot be done in a crisis. Transparency here builds trust and avoids false reassurance. It is critical to discuss any international working with a supervisor.

5 Managing the contracting process

5.1 Contracting to set the context of work

Contracting is central to all therapeutic work and, when clearly agreed from the outset, is critical in supporting work with suicidal clients. It provides an opportunity to be transparent with the client about the boundaries of confidentiality from the beginning of your work together and, if suicide risk emerges, what the therapist and client can expect from each other.

5.2 Being clear about confidentiality

In general terms, under UK law, therapists are not required to break confidentiality automatically if a client speaks about suicide.

However, therapists if employed or volunteering for an organisation may be required to follow an existing policy or procedure; this would be dictated under the contract the therapist has signed with the organisation.

It is important to continue to balance the client's right to autonomy with their safety. Where possible, seeking the client's consent to share concerns with others while keeping accurate records of what was said, what you decided, and why. Notes become part of the ethical accountability for practice.

Confidentiality is not a binary issue, but a nuanced space in which care, trust, and safety must all be held in balance. It is important to revisit and review the contract with clients to further clarify thinking, as well as ensuring the client continues to understand the scope and limits of confidentiality.

6 Supervision and ethical practice

6.1 When should we talk to our supervisor?

It is important to bring suicide risk into supervision regularly, not just when a crisis arises. Having an open dialogue with a supervisor about mutual expectations, thoughts and feelings about suicide is important to explore early, to create a safe working space where client work can be discussed. In moments of acute risk contact a supervisor promptly, but don't delay action if they are unavailable. Discuss the situation as soon as possible afterwards.

Supervision is an important space to discuss a client's likelihood of risk, if further steps might need to be taken, as well as the impact of the work on the therapist, supporting a move from reactive to reflective practice. Supervision can additionally be an opportunity to rehearse responses, consider hypothetical situations, and clarify boundaries. As well as reflecting on the impact of the work, naming emotional responses allows for them to be fully considered and for you to return to your work with greater presence and resilience.

6.2 How do we demonstrate ethical practice?

Ethical practice, as outlined in the *Ethical Framework*, is a commitment to self and the client about the quality and nature of the professional relationship. In working with suicide risk, it is also about a willingness to talk about suicide, not avoid it. It is about how responses are managed in respecting the client's autonomy while also holding their safety in mind.

Being ethical is a relational process, which sits central to the work with suicidal clients. It is not possible, despite best intentions, to ensure a client is always safe. Rather, it is a collaborative process in which the therapist and client work together, where possible, to understand the nature of the suicidal thoughts, their meaning, and ways in which the client might be supported to keep themselves safe, or if other services are required. It involves maintaining the therapeutic alliance even during risk discussions, negotiating consent with transparency, and being present for the client even when their words are difficult to hear. Trust is built not by avoiding discomfort, but by meeting it with transparency, respect and fairness.

6.3 What should we include in a rationale for our decision-making?

When documenting decision-making, it is important to include the rationale which informed the decision-making process. There are several useful elements to include in a good rationale, outlined in Table 2.

Table 2: Creating a rationale for ethical decision-making

1. How did you know the client had thoughts of suicide, and what questions were asked to clarify their thoughts and intentions?

2. What steps will be taken to engage the client in the decision-making process about what actions were needed in response to their suicidal thoughts? If that was not possible, why not?

3. What were the key internal factors considered in the decision-making process?

4. What were the key external factors considered in the decision-making process?

5. What decisions were made and actions taken, what was their outcome?

6. How was the process reviewed, and with whom?

It is important to include if a supervisor, manager or colleague, for example, were consulted and how that informed the decision-making process. If the decision was to maintain confidentiality, explain why and, likewise, if confidentiality was broken, set out the reasons and who was contacted, including the outcome of that referral.

Good records are narrative, not just procedural. They tell the story of the engagement with the client, reflections, and how decisions were made. This narrative can be essential if work is ever scrutinised but additionally provides a good base from which future dialogue can take place.

7 The importance of self-care

7.1 Why is self-care important?

Working with suicide risk, or the completed suicide of a client, can be profoundly challenging. Feelings may include fear, guilt, or self-doubt (Reeves, 2015; Scupham and Goss, 2020). Self-care is a professional necessity when working with suicide risk. It supports emotional resilience, reduces the impact of vicarious trauma, and helps maintain ethical decision-making.

Above all, be honest about emotional or psychological capacity: there will be times when working with risk feels within emotional capacity, and there may be times when it does not. Naming that truth and seeking support are not a failure but rather an ethical strength.

7.2 Practical steps for self-care

Different practitioners at different times will have changing self-care needs. The first important step of self-care is recognising its importance in a busy schedule, and then acting intentionally to adopt self-care strategies. Professional and personal suggestions are included in Table 3, but this is not an exhaustive list; a good 'first-step' to developing a good self-care plan is to create a personalised list.

Table 3: Suggestions for self-care

- Supervision
- Creating a peer-support network
- Regular continuing professional development
- Reviewing emotional capacity to be with clients at risk
- Understanding personal responses and history around suicide that might be present in therapy
- Debriefs, time away from work, or diary-management to 'pace' client work
- Engaging with hobbies and non-therapy activity
- Time outside
- Attending to basic needs: good food, rest and sleep.

8 Application to practice

8.1 Introduction

The following section is aimed at translating the theory covered in this resource into practice with a short case study: Sasha's work with Anya. It also gives you the opportunity to think about your own therapeutic practice by offering questions for you to reflect on.

8.2 Sasha and Anya

Sasha works in private practice and has been meeting with Anya for several weeks. Anya has come to counselling because of low mood and anxiety, and Sasha has noticed they have been particularly low over the last couple of sessions. Sasha was worried about Anya and took these concerns to supervision. Sasha had been worried about Anya having suicidal thoughts but had been concerned about naming it first, for fear of putting these thoughts into Anya's mind, if they had not been thinking this after all.

Sasha's supervisor was encouraging and supportive and helped Sasha have the confidence to speak with Anya directly. At the next session Sasha said, 'I've noticed Anya that you have seemed particularly low recently and wanted to check with you whether your thoughts about yourself had changed at all?

Particularly, I wondered if you have had any thoughts about ending your life?'. Anya was tearful when they replied that yes, they had been thinking about suicide.

8.2.1 Reflections on Sasha and Anya

There are no 'right and wrong' answers here, but rather a chance for you to think about what you have read in this resource and how it helps you to think about this scenario:

- Why do you imagine Sasha was worried about asking Anya directly about suicide? Can you relate to this in your own practice?
- What was helpful about the supervision, do you imagine, that helped Sasha build some confidence in asking about suicide?
- What do you think about how Sasha phrased the question? How did the directness of Sasha's question impact you and would you have asked it differently – if so, how and why?
- What is important next for Sasha and Anya – what would be the next steps in this discussion, in terms of their working relationship, and Anya's wellbeing?

Summary

The therapeutic relationship can provide a structured context for addressing suicidal risk. While such relationships may facilitate disclosure, it remains essential that practitioners support the process through clear, ethical, and professionally accountable decision-making. Ethical and legal frameworks require that decisions related to safety and confidentiality be proportionate, justified, and clearly documented.

Although suicide cannot be accurately predicted, practitioners can apply structured approaches, such as collaborative risk exploration, formulation, and safety planning, to enhance the client's capacity for managing risk. These methods do not eliminate risk but support therapeutic work and provide a sound basis for professional decision-making.

Ultimately, while certainty is not attainable in risk-related work, consistency in applying informed, evidence-based practices contributes to safer and more ethically robust outcomes for both client and practitioner.

About the author

Andrew Reeves, 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 an Emeritus 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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