COSCA (Counselling & Psychotherapy in Scotland)
16 Melville Terrace | Stirling | FK8 2NE
t: 01786 475140
e: info@cosca.org.uk
www.cosca.org.uk

COSCA Guidance on working ethically with suicidal clients

Introduction

792 people died in Scotland of probable suicide in 2023, an increase of 30 on the previous year. The rate of suicidal mortality in males was 3.2 times as high as females and in the most deprived areas 2.5 times as high as in the least deprived.

Figures taken from the National Records of Scotland Probable Suicides report published 13th August 2024

With these figures in mind, it is likely that those working in the counselling and counselling skills professions will, at some point, encounter someone who is having thoughts of suicide or is affected by the suicide of a friend, colleague or family member.

Counselling and counselling skills users should be prepared to allow that person the time and space to explore their thoughts and feelings around suicide without fear of unnecessary intervention or escalation of risk protocols, where this is not appropriate, and in the client or service user's best interests.

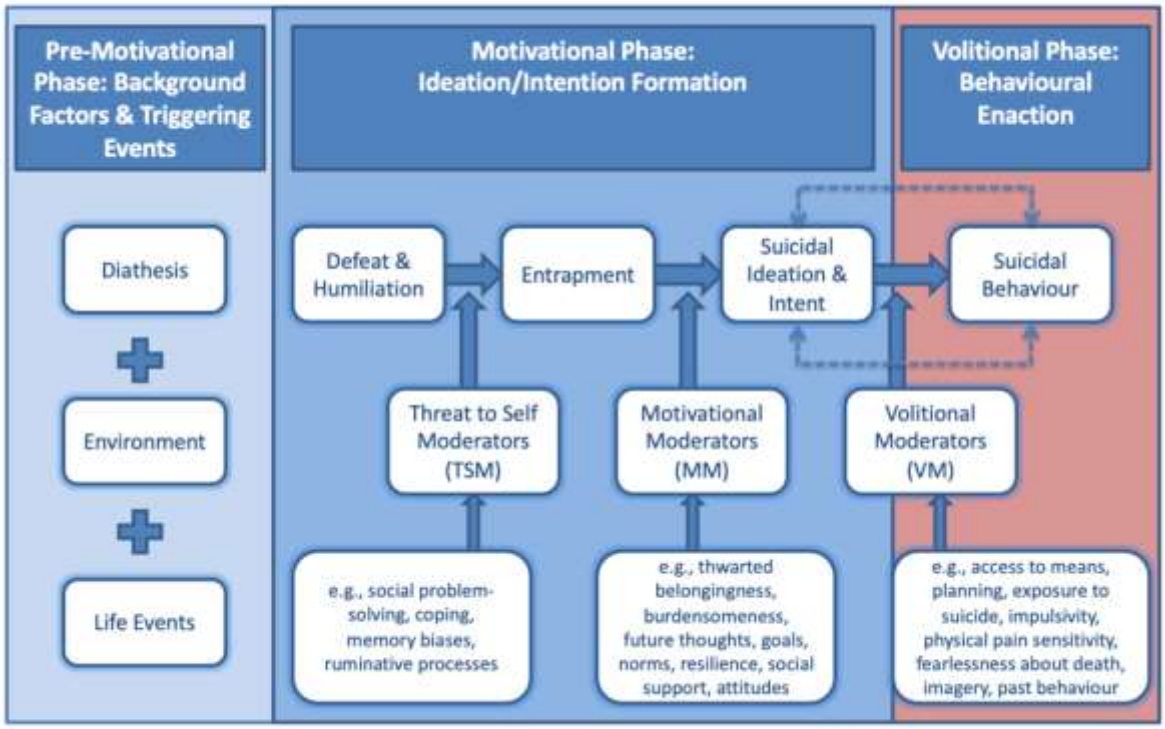
Succumbing to anxiety, and the need to "do something" to minimise the client and/or the counsellor's distress, risks shutting down these important conversations. This exploratory approach is recommended by a large body of research, some of which is included below.

Charity Registered in Scotland No. SC018887
Charitable Company Limited by Guarantee Registered in Scotland No. 142360
December 2024

The IMV model of suicidal behaviour

The Integrated motivational-volitional (IMV) model of suicidal behaviour (first proposed by Professor Rory O'Connor in 2011) aims to describe why people become suicidal and why some people attempt or die by suicide. The model has three parts:

- Background factors i.e. context in which suicide risk may emerge (pre-motivational phase)
- Development of suicidal thoughts (motivational phase)
- The transition from suicidal thoughts to suicidal acts (volitional phase)



Importantly, the model (O'Connor & Kirtley, 2018) makes the distinction between understanding the factors associated with the emergence of suicidal ideation (the motivational phase) and the factors which increase the likelihood that someone will act on their thoughts of suicide (the volitional phase), i.e., engage in suicidal behaviour. People become suicidal when they feel trapped by mental pain (entrapment) which is triggered by feelings of defeat and/or humiliation. This is key to understanding suicide risk. According to the model there are 8 factors called volitional factors (or moderators) which are

associated with whether someone is more likely to engage in suicidal behaviour. They are:

- Access to means
- Planning
- Exposure to suicide or suicide attempts
- Impulsivity
- Pain endurance
- Fearlessness about death
- Mental imagery
- Past suicidal behaviour

So, if someone is having thoughts of suicide, it is important to consider the volitional factors.

For more information see: https://suicideresearch.info/the-imv/

Scotland's Suicide Prevention Strategy covering the period from 2022 to 2032

The Scottish Government published *Creating Hope Together: suicide prevention strategy 2022 to 2032* on 29th September 2022. The strategy takes on board the IMV model and sets out the Scottish Government's plans to address suicide in this ten-year period.

For more information see: https://www.gov.scot/publications/creating-hope-together-scotlands-suicide-prevention-strategy-2022-2032/pages/4/

Policy for suicidal disclosures

It can be daunting to think that a client or service user is having thoughts of suicide, or for a client or service user to first disclose suicidal feelings. Thoughts may turn to competency, working ethically, maybe even being held responsible if the person goes on to take their own life. Having a clear and accessible policy for suicidal disclosures can be invaluable in alleviating some of those fears and enabling the counsellor or counselling skills worker to work openly and calmly with a person expressing thoughts of suicide.

The suicidal disclosure policy and its implications should be made clear to the client or service user, so that they are aware that they can talk with their counsellor or counselling skills worker, and that their own wishes will be respected.

Blanchard and Farber's (2020) study on the barriers to talking about suicide found that "Seventy percent of suicidal ideation concealers cited fear of unwanted practical impacts outside therapy as the reason they did not disclose. Chief among these unwanted impacts was involuntary hospitalization, a perceived outcome of disclosing even mild suicidal thoughts".

People can have strong feelings around suicide, and this includes counsellors and counselling skills workers. They may hold strong beliefs, religious, cultural or from past experience, that suicide is wrong, and this may conflict with the person in front of them.

The COSCA Statement of Ethics and Code of Practice 6.2 states that: *When a potential conflict of interest becomes apparent after the working relationship with a client has commenced, the member has a duty to acknowledge the conflict of interest to the client and seek an equitable resolution to the situation.*

Resolution can mean referring the client to another practitioner or continuing if the member and the client are both satisfied that the conflict of interest will not prejudice the working relationship.

Any policy or procedure should clearly state what should happen in the event of a client or service user expressing thoughts of suicide and what should happen if the counsellor or counselling skills worker feels fundamentally unable to work with it.

In any policy or procedure, the intrinsic value of the counselling or counselling skills relationship should not be forgotten. That human connection cannot be replicated by self-help books, online resources, and self-introspection. In Collins and Cutliffe's (2003) study on suicide interventions, they draw attention to the importance of the therapeutic relationship: "Whether conscious of it or not, the majority of suicidal clients who seek mental health care are at some level seeking a relationship that will bring them some hope; bring them back to a life, instead of a death trajectory."

Those working in counselling and counselling skills professions have a unique relationship with their clients and services users, but especially with those who are having thoughts of suicide, to explore these thoughts and feelings. This should be at the centre of any policy or procedure.

Training in working with suicide

However thorough the assessment process, clients and service users may still present with suicidal feelings later in the relationship, perhaps due to a change in circumstances or feeling more comfortable to disclose them in the therapeutic relationship. Any counsellor or counselling skills worker should be prepared to work with suicidal thoughts or be able to refer on sensitively if they are unable.

The COSCA Statement of Ethics and Code of Practice 2.1 Staes that: *A member offering or providing a service has a fundamental responsibility to have sufficient competence through training, underpinning knowledge, and practice to ensure that the service is effective.*

Specific training on all policies and procedures should be given to those working directly with clients or service users within an organisation, including any reception staff.

COSCA recommends that individual practitioners, where this has not already been covered in their initial training course (COSCA's Validated diploma courses will include a criterion on suicide), attend training on working with suicide and are clear on what they will do if a client presents with suicidal thoughts.

The COSCA Statement if Ethics and Code of Practice 2.2 states that: *A member is required to ascertain that a client's request and/or need for the service offered or provided does not extend beyond the competence of the member. Where a referral to a more appropriate source of help is indicated the member will take steps to encourage the client and to positively refer on.*

All people who have the potential to encounter those experiencing suicidal thoughts should be prepared to work sensitively and supportively with that person, regardless of their job role or individual beliefs, in a way that respects the agency of the person they are working alongside.

Language

It is unhelpful to refer to completing suicide as “committing suicide”, as this suggests a criminality in having thoughts of suicide. The term “committing suicide” is a reference to legislation in England and Wales that was amended in the Suicide Act 1961 and has never applied in Scotland.

“Self-stigma is hugely painful and stigmatising language about suicide and self-harm from professionals, which may have connotations of illegality and therefore shamefulness…” (Royal College of Psychiatrists 2020).

Instead, it is better to use terms such as: experiencing suicidal thoughts / death by suicide / survived a suicide attempt.

“Together, we can change the way the world perceives and treats people facing suicide. The unfortunate reality is that many stigmatizing phrases and ways of talking about suicide have been ingrained into our vocabulary. Even the most dedicated supporters of the mental health movement may find themselves slipping up from time to time, and that’s okay. This does not make you a bad person—it makes you human. If you catch yourself using problematic language about suicide or mental illness, correct yourself out loud. By letting those around you know why your words were harmful, you can turn the conversation into a positive learning experience for everyone involved. If we all put in this effort, we will see a fundamental shift in the way society addresses these issues.” (Canadian Association for Mental Health)

Initial assessment

Current research and advice suggests a shift away from predictive assessment tools as a suicide prevention resource.

“Given the poor predictive value of stratified and scale based approaches to clinical risk assessment (and their negative reception from patients) there is a need for a different approach to risk assessment, with more emphasis on collaborative risk formulation and therapeutic risk management in improving patient care and safety” (Hawton et al, 2022).

This can also be seen in the NICE (2019) shift away from predictive assessment tools as a suicide prevention resource.

However, collaborative assessments, actively exploring the person's needs, strengths and protective factors, can be a valuable tool for a client or service user to disclose suicidal thoughts and be referred to a suitable counsellor, counselling skills user, or an appropriate emergency service.

Andrew Reeves (2022) states that "willingness to ask directly about suicide, without hesitation, embarrassment, awkwardness, or an attempt to 'dress it up', has been one of the most important things I have been able to offer."

It may be that the person is not suicidal themselves, but has been affected by someone who has taken their own life. It is important to give them the space to explore this without any judgement of themselves or the person they are talking about.

Suicide should be actively explored in an assessment process by someone suitably qualified, ideally by a counsellor or counselling skills user, and be included in the training given to those responsible for conducting any assessment or information gathering. It is important that the person conducting the assessment is suitably equipped to open a conversation about suicide rather than being uncomfortable and shutting it down, potentially adding to any shameful feelings around suicide.

For more information see:
https://www.nice.org.uk/guidance/qs189/chapter/Quality-statement-1-Multi-agency-suicide-prevention-partnerships

https://uksobs.com/ for survivors of bereavement through suicide

Safety

The COSCA Statement if Ethics and Code of Practice 4.1 states that: *During the provision of their services, members will take all reasonable measures to ensure the physical and psychological safety of their clients.*

This does not mean that the counsellor, counselling skills user, supervisor, service, or organisation is responsible for the client if they (the client) are feeling suicidal or complete suicide. Instead, it is a responsibility to collaborate with that individual to explore their thoughts of suicide and to assist them to put in place steps that may increase their safety. These steps could include

making a safety plan (see Appendix 1), working on distraction techniques, creating a soothe box (see Appendix 2) etc.

It can be helpful for a counsellor or counselling skills user to acknowledge any need to "do something", to intervene in some way to increase the client or service user's safety, without shutting down their ability to sit with their feelings of suicide and to look at what they may be associated with.

It is important that any plan or technique is created or used in collaboration with the client or service user and maintains their own agency in the process. A counsellor or counselling skills user must respect difference and diversity and understand that what helps one person may be very different for another. Any intervention that makes them feel uncomfortable or left out of the process is not contributing to their safety.

Bear in mind that a safety plan can be a work in progress. It can be revisited and evolve over time, in the work with the client or service user, as new protective factors are identified.

According to the Royal College of Psychiatrists (2020) "It is helpful to:

• take all self-harm seriously and listen carefully, in a calm and compassionate way;

• take a validating and non-judgemental approach;

• help the person to identify their own coping strategies and support network;

• offer information about support services."

For more information see:

https://stayingsafe.net/

See also Appendix 1: example safety plan and Appendix 2: example soothe box.

Onward referral

The COSCA Statement of Ethics and Code of Practice 5.3 states that: *A member will not disclose any information about a client to a third party without the permission of the client.*

and

COSCA Statement of Ethics and Code of Practice 5.4 *Exceptionally, a member may disclose information obtained during the working relationship with their client in the interests of the safety of the client and/or others. In advance of this disclosure, whenever practicable, the client's permission will be sought, and the client-work supervisor consulted.*

Individuals and organisations must be able to refer on to other services both nationally and locally. Some national services can be found in Appendix 1: example safety plan.

Counselling is not an emergency service and so there may be a need to refer to a specialised, often counselling skills-based, service such as NHS 24 111 (Mental Health Hub), Breathing Space (NHS 24), or an emergency service. This should be completed in collaboration with the person expressing suicidal thoughts and they should be empowered, wherever possible, to make their own referral.

For examples of possible services for referral see:

Appendix 1: Example safety plan

Self-harm

Self-harm is too big a topic to be covered in this guidance and requires separate consideration. It is mentioned here as it is often seen as a risk factor, even when this is not the case. Self-harm may be an indication of distress, but it is also important to acknowledge that it is serving a purpose: to regulate that distress.

Klonsky's (2009) study found that self-injury was used "to release emotional pressure that builds up inside of me," "to control how I am feeling" and "to get rid of intolerable emotions" most often, with a release of emotional pressure being chosen by 85% of those in the study as their main reason.

Nock (2009) examines NSSI (Non-Suicidal Self Injury) as a means to regulate their affective and social experiences and puts forward six hypotheses (social learning, self-punishment, social signalling, pragmatic, pain analgesia/opiate,

and implicit identification) for why NSSI is used to regulate emotions when there are other non-injurious methods.

It is important to explore the whys of self-harm rather than seeing it as a risk that needs to be reported and stopped with no exploration.

To find out more about self-harm, including free training, see Penumbra's Self Harm Network https://selfharmnetworkscotland.org.uk/ .

Support for those working with suicide

Working with thoughts of suicide is hard and it is important that the individual practitioner seeks out support and that support is offered by counselling and counselling skills organisations.

It is vital to have support in place for the counsellor, counselling skills user, or counselling service worker if the client or service user completes suicide.

Gitlin (1999) talks about the sadness, shame, guilt, anger, isolation, and fear of consequences that a mental health professional can feel after a death by suicide and suggests that decreasing the sense of isolation, making efforts at reparative, constructive behaviour, and using specific cognitive defences are most important methods for coping.

People who have worked with clients or service users that have contemplated suicide need support from their organisation, colleagues, and supervisor so that they are not alone when dealing with the effects of suicide, whether the person completes suicide, attempts or is having thoughts of suicide.

Counselling supervision

Supervisors are not responsible for the client if they are feeling suicidal or go on to complete suicide, but supervision may be the main source of support for most counsellors working with suicide.

A counsellor or counselling skills worker may be going to their supervisor out of fear of prosecution and perhaps to protectively document the interventions they have put in place. This can be helpful, if only to alleviate some of those fears, but is only part of the supervisor's commitment to client and supervisee

safety. Supervisors need to be willing, able and, most importantly to encourage, their supervisee to explore their thoughts and feelings around suicide and how that affects their therapeutic relationship with their client.

Supervisors should also have in place the ability to offer extra support where necessary, be this an ad hoc phone call or extra supervisory sessions.

The COSCA Statement of Ethics and Code of Practice 4.6 states that: *Client-work supervision is used by members as part of the process of ensuring practitioner and client safety within the working relationship.*

Supervisors should be involved throughout the course of working with a client or service user with suicidal thoughts to offer support and guidance where necessary.

Independently reviewed by Professor Rory O'Connor, University of Glasgow and Tony McLaren, Breathing Space.

S**ummary of Resources** (please check that information is still current before passing to clients)

The Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour: https://suicideresearch.info/the-imv/

Staying safe from suicidal thoughts: https://stayingsafe.net/

Appendix 1: example safety plan

Appendix 2: example soothe box

Penumbra's Self Harm Network: https://selfharmnetworkscotland.org.uk/

References

Blanchard M, Farber BA. "It is never okay to talk about suicide": Patients' reasons for concealing suicidal ideation in psychotherapy. Psychotherapy Res. 2020 Jan;30(1):124-136. doi: 10.1080/10503307.2018.1543977. Epub 2018 Nov 8. PMID: 30409079.

Canadian Association for Mental Health "Words matter. Learning how to talk about suicide in a hopeful, respectful way has the power to save lives". https://www.camh.ca/en/today-campaign/help-and-resources/words-matter (Accessed: 18/04/24)

Collins, F. & Cutliffe, J. R. (2003), Addressing hopelessness in people with suicidal ideation: building upon the therapeutic relationship utilizing a cognitive behavioural approach: https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1365-2850.2003.00573.x

Gitlin M, J. (1999) A psychiatrist's reaction to a patient's suicide. American Journal of Psychiatry, 156: 1630–34

Hawton et al. (2022) Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management. The Lancet Psychiatry, Published Online August 8, 2022 https://doi.org/10.1016/S2215-0366(22)00232-2

Klonsky ED (2009) The functions of self-injury in young adults who cut themselves: clarifying the evidence for affect-regulation. Psychiatry Res, 166: 260–8

Mulholland, F. on the ASB178 Assisted Suicide (Scotland) Bill https://archive2021.parliament.scot/S4_HealthandSportCommittee/Assisted%20Suicide%20Bill%20submissions/LordAdvocateASB178.pdf

National Records of Scotland Probable Suicides report published 13th August 2024

Nock, M. K. (2009) Why do People Hurt Themselves? New Insights into the Nature and Functions of Self-Injury. Curr Dir Psychology Sci, 18: 78–83

O'Connor, R.C., Kirtley, O.J. (2018). The Integrated Motivational-Volitional Model of Suicidal Behaviour Philosophical Transactions of the Royal Society B. 373: 20170268

Reeves, A. (2022) Suicide risk: explore or evade? Healthcare Counselling and Psychotherapy Journal, July 2022 https://www.bacp.co.uk/bacp-journals/healthcare-counselling-and-psychotherapy-journal/july-2022/suicide-risk/ Accessed 21/02/24

Royal College of Psychiatrists. Self-harm and suicide in adults: final report of the patient safety group. [Online.] London: Royal College of Psychiatrists; 2020. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr229-self-harm-and-suicide.pdf?sfvrsn=b6fdf395_10 (accessed February 2024).

Suicide Act 1961 CHAPTER 60 9 and 10 Eliz 2 England and Wales Available at https://www.legislation.gov.uk/ukpga/Eliz2/9-10/60 (accessed 28/02/24).

Appendix 1: example safety plan (from https://stayingsafe.net/ST/)

Getting through right now:

- Activities to share hope
- Things that mean something
- Strategies to “help get me through”
- Emergency activity to buy time
- Helpful thoughts

Making your situation safer:

- What can you do immediately to improve your safety?
- Is there a place you can get to easily where you feel safer?
- What can you do in the longer term to improve your safety?
- Can you remove anything you might use for hurting yourself?
- If you need regular medication, could you store it somewhere safely or perhaps store a small amount in your house?
- Is there anyone you trust to look after some of it for you?

Things to lift or calm your mood:

- Connecting with someone
- Calming activities
- Activities involving exercise
- Distracting activities to ‘keep me busy’
- Creative activities
- Concentration activities
- Entertainment activities
- Positive reminders of life

Things to distract you:

- List anything to ‘take your mind away’ from distressing feelings and keep you busy.
- Try to be specific. For example, if it involves contacting someone write their name and exactly how you will contact them i.e., in person, messaging, by text or by phoning them, and include all their contact details.

People to support you:

- Add the names of people to message or get in touch with just for a chat and not necessarily to tell them about your feelings in any detail.
- Write all their contact details and when you can contact them.

List who you can talk to if you are distressed or thinking about self-harm or suicide:

- Childline, 0800 1111, 24/7
- Breathing Space, 0800 83 85 87, 18:00 – 03:00 Mon-Fri, 24hrs Sat Sun.
- Campaign Against Living Miserably (CALM, focused on male suicide), 0800 58 58 58, 17:00 – 0:00 Mon-Sun
- National Suicide prevention Helpline UK, 0800 689 5652, 18:00 to 0:00 Mon-Sun
- PAPYRUS, Prevention of Young Suicide, 0800 068 4141, 24/7
- Samaritans, 116 123, 24/7
- SANEline, 0300 304 700, 16:00 – 22:00 Mon-Sun
- SHOUT (Text only service) 85258 24/7
- Switchboard (LGBTQIA+), 0800 0119 100 10:00 – 22:00 Mon-Sun
- Andy's Man Club Meets Mondays at 7pm (except bank holidays) at various locations throughout the UK.
- Suicide Prevention Scotland Advice and resources for suicide.
- YouTube Suicide Prevention Scotland’s YouTube videos

Professional support:

- My GP (family doctor)

- My mental health team or Care Co-ordinator
- NHS 24, 111

Appendix 2: example soothe box

Sight

When things feel overwhelming, some people find it helpful to have visual reminders of people, places, pets, and memories that are important to them.

You could include:

- Photos of people, pets, or happy memories
- Writing about happy memories or occasions
- A letter to yourself that you have written when you are in a calmer, happier place
- Notes or messages from people you care about
- Positive quotes, affirmations, or song lyrics that are meaningful for you
- A glitter jar
- Positive affirmations

Hearing

Make it easier for yourself to find sounds that soothe or calm you by putting things in your box in advance.

You could include:

- Some headphones (if you keep a pair in your box, you will not have to search for them)
- A link to a playlist of music that makes you feel happy, calm, or relaxed
- A link to a video that makes you feel happy, calm, or relaxed, like a seaside scene
- Ear plugs if you find noise overwhelming

Touch

There is an abundance of scientific research and explanations about how and why touch can calm people down, but you do not need to understand the science to try it for yourself.

You could include:

- Fidget toys (there are loads available, so you could try a couple of different types)
- Playdough or clay (or you could make your own salt dough)
- Something soft (a soft toy, blanket, or pair of fluffy socks)
- A hand or face mask
- Temporary tattoos

Smell

Different people find different scents calming – you could use a scent you associate with a calm place or try to find something new.

You could include:

- Hand cream or moisturiser
- Essential oil (do some research if you have pets, as some are harmful)
- Room spray
- Perfume or cologne

Breathing

We know that people sometimes get into a cycle where their breathing makes them feel anxious, and then that anxiety makes it tricky for them to breathe as calmly as they normally would. If this happens to you, you could include some things in your box to help.

You could include:

- NHS breathing exercises for stress (you could print or copy this page)
- A bottle of bubbles to encourage you to breathe out in a slow, steady way

Get in the flow

Sometimes, when things feel overwhelming, people find it calming or relaxing to give their brain something else to do. This might be especially helpful if you find yourself worrying about things repeatedly.

You could include:

- Colouring book or sheet (do not forget to include some pens or pencils too)
- A simple craft (you could include a kit or try something like origami)
- A puzzle book (choose your favourite type of puzzle, from crosswords to sudoku)
- A pen and a notepad
- Nail varnish
- Playing cards (you could learn to play clock solitaire or spider solitaire as they are games for one player)

Support

It is not always easy to reach out when you do not feel great. Make it easier for yourself by creating a list of people and organisations you can contact to add to your box.

You could include:

- Names of friends or family you can contact (and their phone numbers)
- Information about different organisations – check out the 'Get help now' page for some ideas

Adapted from: https://bestforyou.org.uk/how-to-make-a-self-soothe-box/