Guidelines relating to suicidal clients

1. Introduction

1.1. Psychologists, by the nature of their work, are likely to encounter *clients* with suicidal thoughts. These *clients* may also have a history of suicidal behaviour and/or express an intent to harm or kill themselves now or in the future. These thoughts or behaviours are typically the result of many interacting factors.

1.2. These *Guidelines* outline some general and specific principles that should be taken into account by all *psychologists* in dealing with suicidal clients. Where appropriate and possible reference is made to the relevant sections in the Code, and relevant *Guidelines*.

1.3. It is important to note that these *Guidelines* highlight key principles for *psychologists* to follow, and are not practice guidelines.

1.4. While the welfare of *clients* is paramount, *psychologists* may also face a professional risk when working with suicidal *clients*. These *Guidelines* have been devised to assist *psychologists* to give consideration to the professional matters that are relevant to this specific *client* group, within the context of established regulatory bodies such as Psychologists Registration Boards and Health Care Complaints Commissions.

2. Training, experience and supervision

2.1. It is important for all *psychologists*, as a basic requirement, to acquire knowledge and training in how to recognise, assess and refer a person at risk of suicide.

2.2. Any *psychologists* working with high-risk populations or engaged in ongoing work with suicidal *clients* need to have training, experience and supervision relevant to their role and responsibility and to consult appropriately qualified persons as needed.

2.3. *Psychologists* familiarise themselves with knowledge, skills and standards of care relevant to their work with suicidal *clients* through relevant literature and training.

2.4. *Psychologists* familiarise themselves and comply with legislation that may be relevant to their work with suicidal *clients*. See also Section 5 below.

2.5. There are many potential ethical dilemmas working with this *client* group. These can include creating space to talk about what can be a sensitive subject, respecting the *client's* autonomy, and deciding whether and when to intervene. Sometimes these different elements will be in competition with each other. For such situations, *psychologists* are encouraged to seek consultation with an experienced colleague.

3. General overview

Refer to the APS *Code of Ethics* (2007), standard B.3. Professional responsibility.

> B.3. *Psychologists* provide *psychological services* in a responsible manner. Having regard to the nature of the *psychological services* they are providing, *psychologists*:
> (a) act with the care and skill expected of a competent *psychologist*;
> (b) take responsibility for the reasonably foreseeable consequences of their *conduct*;
> ...
> (e) are personally responsible for the professional decisions they make;
> ...

Refer to the *Code*, standard B.1. Competence.

> B.1.1. *Psychologists* bring and maintain appropriate skills and learning to their areas of professional practice.
>
> B.1.2. *Psychologists* only provide *psychological services* within the boundaries of their professional competence. This includes, but is not restricted to:
> (a) working within the limits of their education, training, supervised experience and appropriate professional experience;
> (b) basing their service on the established knowledge of the discipline and profession of psychology;
> (c) adhering to the *Code* and the *Guidelines*;
> (d) complying with the law of the *jurisdiction* in which they provide *psychological services*; and
> (e) ensuring that their emotional, mental, and physical state does not impair their ability to provide a competent *psychological service*.

Refer to the *Code*, standard A.1. Justice.

> A.1.1. *Psychologists* avoid discriminating unfairly against people on the basis of age, religion, sexuality, ethnicity, gender, disability, or any other basis proscribed by law.
>
> A.1.2. *Psychologists* demonstrate an understanding of the consequences for people of unfair discrimination and stereotyping related to their age, religion, sexuality, ethnicity, gender, or disability.
>
> A.1.3. *Psychologists* assist their *clients* to address unfair discrimination or prejudice that is directed against the *clients*.

3.1. Many *clients*, even when suicidal, experience ambivalence about living and dying, and would prefer to find help to deal with their problems. Consequently, a basic guiding principle for *psychologists* is to promote *clients'* safety and support, pending a more thorough assessment of their needs, situation, and options for further help. *Psychologists* must at all times respect their *clients'* autonomy while also helping them identify and address psychological and circumstantial factors affecting decisions they are making about their life and safety.

3.2. In making these decisions, *clients* may indicate their ambivalence by expressing a desire to kill or deliberately harm themselves while at the same time seeking help to address problems in living. It is important for *psychologists* to understand and work with these conflicting thoughts and behaviours in ways that acknowledge the pain and desperation behind them while attending to immediate safety and strengthening supports for living.

3.3. *Psychologists* are aware of their own personal attitudes and values about suicide and suicide intervention, and whether those attitudes and values influence their professional judgement and response. Where *psychologists* identify attitudes and values that may interfere with their professional judgement, they seek consultation with a colleague and consider whether alternative treatment options are needed.

3.4. *Psychologists* are aware that some *client* sub-groups, e.g., terminally ill *clients*, have an elevated risk of suicide. *Psychologists* familiarise themselves with the research related to this area, and have an appreciation of the socio-cultural contexts that are associated with that heightened risk.

4. Specific principles

In their dealings with potentially suicidal *clients*, *psychologists* are guided by several specific principles:

4.1. Client safety

4.1.1. *Psychologists* remain alert to *clients'* current and ongoing signs of suicide risk. If signs are present, *psychologists* are ethically obliged to:
i) take steps to attend to the *client's* immediate safety; and
ii) undertake or arrange for a thorough and specific assessment of suicide risk; and
iii) if necessary, arrange appropriate psychological, medical, psychiatric and/or social care, and community response.

4.1.2. *Psychologists* have an ethical responsibility to have knowledge of, and use current practice guidelines that cover the following points:

4.1.2.1. Assessment is comprehensive in nature, addressing suicidal thoughts and behaviours directly in ways that attend to the pain, understand the potential for despair behind it, and provide foundations for immediate safety and ongoing help;

4.1.2.2. *Psychologists* explore the *client's* resilience and the existence of any protective factors, and build on the client's strengths;

4.1.2.3. Some assessment considerations are contextual and/or cultural. For example, it is pertinent to identify how factors in the *client's* past, current, or imagined future situation may be contributing to suicidal thoughts or acts, and to understand the meaning and significance they attach to these experiences. Family and significant others, and the sense of connection to them, are also relevant;

4.1.2.4. The mental health of a *client* features in any assessment of risk, as well as determination of needs for follow-up care and options for treatment planning. The *client's* mental health will affect how they view their current situation, their vulnerability to suicide, coping strategies, perceptions of options for help and openness to seeking help. There may be occasions that involve the need for administration or monitoring of medication, which would require the involvement of a psychiatrist and/or general practitioner;

4.1.2.5. A comprehensive assessment will also address factors specific to the presence, immediacy and level of risk, such as prior suicidal behaviour, suicide plans, access to means, evidence of impulsive behaviour and the *client's* use of alcohol or drugs;

4.1.2.6. While many common factors inform the assessment of suicide risk, each *client's* suicidal crisis needs to be individually understood and responded to. Internal and external factors in the *client's* life and that *client's* unique way of responding to them will facilitate an assessment that provides safe and helpful outcomes for the *client*. To assist this process *psychologists* are directed to relevant literature and training in managing suicidal *clients*;

4.1.2.7. *Psychologists* working with a suicidal *client* maintain a duty of care at least until an appropriate management plan has been developed and implemented and, if necessary, care has been passed on by mutual agreement to an appropriate professional or agency; and

4.1.2.8. Both assessment and response must be considered within the context of the need to maintain engagement with the suicidal *client* and the need to encourage the *client* to mobilise as much as possible their own resources and supports. However, it also needs to be recognised that the *client* may exhibit temporary limits in their capacity to mobilise resources, requiring a more active role from those attending to their safety and care.

4.2 Safety of others

4.2.1. While the focus with suicidal *clients* is on their immediate safety, those providing intervention also recognise and address factors that may pose direct risk to others (e.g., where suicide might be attempted by firearms, weapons, arson or motor accident, or involve potential homicide-suicide).

4.2.2. Where a suicidal *client* has dependent children, *psychologists* are aware of, and if necessary address, protective issues for those children.

4.3. Impact on others of suicidal behaviour

Psychologists are aware of the powerful and painful impact of suicidal behaviour on others, especially when it results in a death by suicide. Psychological support may be needed not only by those intimately affected (such as family and friends) but also by those linked in some other way to the person who committed suicide. Examples include suicides in educational, work and sports settings, or situations where people may identify strongly with a public figure who took his or her life. If a *client* commits suicide, the *psychologist* treating the *client* may have their own particular needs for support. In all these situations, provision of care needs to be matched by vigilance about potential suicide risk among those affected.

4.4. Confidentiality

Refer to the *Code*, standard A.5. Confidentiality.

A.5.2. *Psychologists* disclose confidential information obtained in the course of their provision of *psychological services* only under any one or more of the following circumstances:
(a) with the consent of the relevant *client* or a person with legal authority to act on behalf of the *client*;
(b) where there is a legal obligation to do so;
(c) if there is an immediate and specified risk of harm to an identifiable person or persons that can be averted only by disclosing information; or
(d) when consulting colleagues, or in the course of supervision or professional training, provided the *psychologist*:
    (i) conceals the identity of *clients* and *associated parties* involved; or
    (ii) obtains the *client's* consent, and gives prior notice to the recipients of the information that they are required to preserve the *client's* privacy, and obtains an undertaking from the recipients of the information that they will preserve the *client's* privacy.

Refer to the *Code*, standard A.4. Privacy.

A.4. *Psychologists* avoid undue invasion of privacy in the collection of information. This includes, but is not limited to:
(a) collecting only information relevant to the service being provided; and
(b) not requiring supervisees or trainees to disclose their personal information, unless self-disclosure is a normal expectation of a given training procedure and informed consent has been obtained from participants prior to training.

Refer to the *Code*, standard A.3. Informed Consent.

A.3.6. *Psychologists* who work with *clients* whose capacity to give consent is, or may be, impaired or limited, obtain the consent of people with legal authority to act on behalf of the *client*, and attempt to obtain the *client's* consent as far as practically possible.

4.4.1. Any decision to engage professional or social supports to manage the suicidal crisis raises issues about disclosing information that has been provided to the *psychologist* in confidence. In making such a decision, *psychologists* take into account the quality of these relationships and the capacity of those involved in providing support to respond appropriately.

4.4.2. Permission to contact professional or social supports is obtained from the *client* where possible, and disclosure is, at least in the first instance, limited to information pertinent to the suicide risk and the prevention of suicidal behaviour. If consent is not obtained, other protective interventions may need to be made. For situations where it has not been feasible to obtain the *client's* consent to inform other persons, an assessment of the degree of risk to the *client* and others will determine whether to breach confidentiality. The immediate safety of the person at risk is paramount.

4.4.3. In the case of young persons, this typically involves *psychologists* advising at least one relevant caregiver (e.g., parent, guardian, next of kin). In circumstances where advising a relevant caregiver is not appropriate, *psychologists* work with the *client* to identify one or more appropriate person/s to contact.

4.5. Role clarity and competence

Refer to the *Code*, standard B.1. Competence.

B.1.2. *Psychologists* only provide *psychological services* within the boundaries of their professional competence. This includes, but is not restricted to:
(a) working within the limits of their education, training, supervised experience and appropriate professional experience;
(b) basing their service on the established knowledge of the discipline and profession of psychology;
(c) adhering to the *Code* and the *Guidelines*;
(d) complying with the law of the *jurisdiction* in which they provide *psychological services*; and
(e) ensuring that their emotional, mental, and physical state does not impair their ability to provide a competent *psychological service*.

Refer to the *Code*, standard B.11. Termination of psychological services.

> B.11.5. When confronted with evidence of a problem or a situation with which they are not competent to deal, or when a *client* is not benefiting from their *psychological services*, *psychologists*:
> (a) provide *clients* with an explanation of the need for the termination;
> (b) take reasonable steps to safeguard the *client's* ongoing welfare; and
> (c) offer to help the *client* locate alternative sources of assistance.

4.5.1. The level of expertise required depends on the level of involvement of the *psychologist* in the care of the *client*.

4.5.2. Where a suicide risk emerges during work with existing *clients*, *psychologists* address issues of immediate safety as outlined in standard 4.1, and then clarify the nature and extent of the *client's* needs for continuing care. This is worked out collaboratively with the *client* and appropriate consultation with a supervisor and/or colleague.

4.5.3. Should a *psychologist* appraise a *client's* suicide risk and associated circumstances as beyond their professional competence, referral to or advice from an appropriately experienced colleague or other practitioner, or referral to or liaison with an appropriate agency, is required. Those making and accepting the referral should define their respective ongoing roles and ensure that these are clearly understood by the *client*.

4.6. Collaboration/consultation/referral

Refer to the *Code*, standard B.4. Provision of psychological services at the request of a third party.

> B.4. *Psychologists* who agree to provide *psychological services* to an individual, group of people, system, community or organisation at the request of a third party, at the outset explain to all parties concerned:
> (a) the nature of the relationship with each of them;
> (b) the *psychologist's* role (such as, but not limited to, case manager, consultant, counsellor, expert witness, facilitator, forensic assessor, supervisor, teacher/educator, therapist);
> (c) the probable uses of the information obtained;
> (d) the limits to confidentiality; and
> (e) the financial arrangements relating to the provision of the service where relevant.
> ...

Refer to the *Code*, standard A.4. Privacy.

> A.4. *Psychologists* avoid undue invasion of privacy in the collection of information. This includes, but is not limited to:
> (a) collecting only information relevant to the service being provided; and
> (b) not requiring supervisees or trainees to disclose their personal information, unless self-disclosure is a normal expectation of a given training procedure and informed consent has been obtained from participants prior to training.
> ...

4.6.1. Given the qualitative nature of suicide risk assessment, accessing consultative support from an experienced colleague or other practitioner is considered in order to ensure adequacy of the assessment, risk management and ongoing care.

4.6.2. In cases where *psychologists* choose to refer the *client* for professional support from others as well as, or in place of, their ongoing involvement, this is done in a supportive way that strengthens continuity of care.

4.7. Record keeping

> Refer to the *Code*, standard B.2. Record keeping.
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> B.2.1. *Psychologists* make and keep adequate records.
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> B.2.2. *Psychologists* keep records for a minimum of seven years since last *client* contact unless legal or their organisational requirements specify otherwise.
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> B.2.3. In the case of records collected while the *client* was less than 18 years old, *psychologists* retain the records at least until the *client* attains the age of 25 years.

As with all psychological casework, clear documentation is essential. This should include reference to the circumstances surrounding the suicidal crisis, risk assessments, clinical decisions, steps taken to address safety, persons consulted and the nature and extent of these consultations. Rationale for intervention steps taken and the basis for any considered disclosure of information to appropriate third parties is also included.

5. Legal implications

Psychologists are aware of laws at the federal, state and territory level that relate to suicide. This includes, but is not limited to, laws against "assisted suicide".

6. References

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7. Further reading

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