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Guidance for Supporting Suicidal Clients

At Survivors' Network, we are brave, we are compassionate, we are empowering and we are collaborative. These values guide how we interact with each other and serve our community.

This means:

We centre survivors in everything we do

We pay attention to and transform power

We practice care and love

We tackle intersecting forms of oppression

We build a culture of openness and are open to change

We do the work

We believe that by living these values, we can create a stronger and more effective organisation that makes a meaningful difference in the world.

We strive to ensure that these values are reflected in the creation and implementation of all Survivors' Network policies.

At Survivors' Network we recognise the devastating impact of sexual violence on survivors' lives. One of the many impacts of abuse may be that thoughts of suicide may arise. We believe it is important to have open conversations about this with our clients, especially as suicide can be a taboo subject and those who consider, attempt or complete suicide can be heavily stigmatised and judged. Thoughts of suicide are surprisingly common with 1 in 5 people in the UK having suicidal thoughts and 1 in 20 will attempt suicide.[1] At Survivors' Network, we believe in empowerment and working alongside our clients to support their healing. We respect and trust in them that they are the absolute experts in their experiences.

Survivors describe feeling powerless as a result of their experiences of sexual violence. Survivors' Network works to actively avoid the removal of power from our clients. It is our policy not to automatically share information with statutory services if an adult client discloses thoughts about taking their own life, but to work closely with the client so that they retain as much control as possible throughout. This must be balanced with our legal obligations and, as such, it may at times be

necessary to act without the direct agreement of a client. While we work to a model of empowerment and choice, we also recognise the significant impact that a client's death by suicide can have on the member of staff or therapist as well as the impact on their friends, family and community. It is always preferable for the client to seek support for themselves at the earliest possible stage and where this is not possible, for any contact with statutory services to be with the survivor's support. We need to be able to demonstrate that we have carefully considered the client's right to autonomy and confidentiality against the risk of harm to themselves and others.

After a conversation with the client about their feelings and plans including any protective features, if a member of staff believes, 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 staff member acts on their concerns quickly and appropriately.

We recognise that all staff and volunteers have a duty of care to clients who are intending to harm themselves, especially young people under the age of 18 or vulnerable adults[ii]. Where staff and volunteers have concerns for clients who can be defined as under the age of 18 or as a vulnerable adult, reference should also be made to our Child and Adult Safeguarding Policies.

Supporting suicidal clients who have dependants

Where a client has suicidal thoughts and an intention to act on these thoughts, and they have dependents, either in their care or elsewhere, then please refer to the Child and Adult Safeguarding policies and ensure that you act in order to safeguard the child/vulnerable adult as a priority.

Training and Support

Supporting suicidal clients can be challenging and impactful for staff and volunteers. All new staff at Survivors' Network must undertake ASIST training within the first 6 months of starting work with us. The volunteer training includes a section about supporting suicidal clients and all volunteers who support clients must attend this training as part of the induction process. All staff and volunteers have access to clinical supervision to discuss the impact of supporting survivors who are at risk of suicide.

We will never be able to anticipate every situation in which an SN team member may be supporting someone with suicidal feelings, which is why staff are not expected to make decisions in isolation, are expected to discuss the risk and possible next steps wherever possible and will be supported in making defensible decisions, based on their assessment of risk, reference to relevant policies, and knowledge in this area. There is an intention to always have a daytime emergency manager at all SN buildings for safeguarding and other emergency concerns. If they are not available, there will be a manager available over the phone for support. After 5pm, there will also be an on-call manager who can support with these concerns.

Where a worker or a volunteer have been affected by suicide, whether completed or not, Survivors' Network will work closely with the individual affected to ensure that they receive increased levels of support and supervision.

Supporting Clients

It is vital that case notes are up to date and comprehensively cover all contact with the client and third parties when suicide is discussed or there are concerns regarding risk of harm.

While supporting a client, we may ask about the impact of sexual violence on their lives. We will actively listen for invitations to talk about suicide and will directly and sensitively enquire about suicide

if we notice these invitations. If appropriate to do so, we will ask clarifying questions if the response given is ambiguous or unclear.

Many of our clients express currently having, or previously having had suicidal thoughts. In these instances, we recognise that suicidal thoughts can be part of processing trauma and we would offer the client the opportunity to explore these thoughts and to support them with safety planning. We would not automatically pass on information about any clients' suicidal thoughts.

If a client is talking about suicide but does not have an imminent plan, then we will discuss referring to mental health services or supporting the client to make an appointment with their GP. In keeping with our empowering model, we would (where appropriate) encourage the client to reach out for support themselves and offer support to enable them to do this as independently as possible. If this is not possible, we can make these referrals on their behalf.

After a supportive conversation with exploration of the issues and proportionate safety planning, it may be that no referrals to third parties are required at this stage. Choosing not to share or to share information without the explicit agreement from the client requires consideration and the ability to clearly state the rationale for your actions. Ensure that you keep a written record of your conversation and decision making at the earliest opportunity.

It may help to structure your deliberations in your case notes under the headings below. The decision to share with a third party must carefully consider:

1. The common law duty of care: we must take reasonable steps to prevent foreseeable harm to others. It is our professional obligation to safeguard clients, while they are using our services**.** This means always acting in their best interests, not acting (or failing to act) in a way that causes harm.
2. Whether the client is a vulnerable adult or under 17: increases our responsibility to act on any concerns
3. The likelihood of serious harm to themselves or others: the greater the likelihood of serious harm, the greater the incentive to share
4. Our empowerment model that treats all clients as experts in their own lives and seeks to provide clients with choice and control over these decisions
5. The possible negative impact of sharing the information on the therapeutic or support relationship and the possibility of increased harm in the longer term

If possible, engage the client to find out more information about their plans and intentions, although this is not always possible, particularly where the client disengages from a phone or text conversation.

Though we would encourage a client to share so that we can clarify the level and severity of risk, we would not prevent a client from leaving the building if this conversation was happening face to face. Where the level of risk is unknown or ambiguous, it is especially important to discuss next steps with a manager as the decision to act will be influenced by (but not limited to) the immediate context, their level of distress / intent, their history and protective features in their lives.

Calling Emergency Services / requesting a welfare check

When the level of risk of immediate harm is high (they are about to or have already taken steps to end their lives) and we are aware of the client's location, we may have to call the emergency services to assist. Your manager or the daytime manager / on call manager can support with this decision and intervention. If possible, the worker should remain on the call or stay with the client and enlist a colleague to call emergency services. If not possible, the worker should end the call with the client (agreeing to call them back if appropriate) while calling for assistance.

Staff should call 999 and request an ambulance. Please have as much information as possible available including location of client, any relevant history, any medication taken, whether they are alone or with someone else (including dependents), any issues of capacity or any special vulnerabilities (including mental health issues or learning needs). If you think that there is a risk that the client could be hostile to the emergency services being involved or may not open the door or may jeopardise others in their attempt to end their lives, it is important to let the call handler know so that they can request police support. If you have concerns about a survivor's (or anyone else's safety) but there is not an immediate risk of harm, you can contact the non-emergency contact centre on 101 and request a welfare check. This is not be used when there is an urgent need but where you are unsure of the risk or the risk level is lower.

Staff members and volunteers are not able to accompany service users to Accident and Emergency.

Guidance for supporting children and young people age 17 and under and vulnerable adults

Children and young people are especially vulnerable and we must always act to protect them from harm. Where a client is age 17 and under and the client expresses a suicidal intention and has a plan, we must always act to share this information. If there is an imminent risk to the client's life, please call emergency services. If there is a plan but no immediate intention, please make a safeguarding referral or contact the client's social worker or another relevant professional, If safe to do so, inform the child or young person's parent or carer.

As with adults, include the client in this process if it is at all possible unless you feel that doing so will increase their danger.

Guidance for supporting an adult client who expresses an intention to end their life and has an imminent plan and we do not have their contact details

While supporting a client, we will be mindful of the warning signs of suicide [iii] or invitations from clients not only in what they directly tell us but also what we can observe in their behaviour and mood. We will proactively respond to these invitations, where possible and ask direct and sensitive questions about their thoughts and plans to end their lives. When we understand that a client has an intention to act on an imminent plan to end their life, we must take immediate action.

It is important to thank the client for reaching out and let them know that we are worried about them. Gather as much information as possible about their location and circumstances (it may be useful to have a description of what they are wearing if they are in an outdoor location) to pass onto the emergency services. If we are aware of where the client is, enlist a colleague to contact the emergency services on another line whilst keeping the client engaged. If this is not possible, then take the clients number and call them back after having called the emergency services.

Guidance for supporting an adult client who expresses an intention to end their life and has an imminent plan and they are known to the service.

Where a client is known to our service, and we have contact details for the client and they disclose that they have an intention to end their life, they have a plan and intend on acting on it, then we have a responsibility to act. It is important to thank the client for sharing their feelings with us and let them know that we are worried about them. It may be necessary to remind a client of our confidentiality agreement. If you make an assessment that it is necessary to share information with a third party, let the client know this and ask how they would like to go about it. In line with our empowering model of support, where appropriate and safe to do so, we would also encourage a client to contact the third party themselves. We should always inform the client, unless you assess that in doing this, you will

increase the level of risk to them or others. Agree an immediate safety plan with the client, if possible, to keep them safe until the third party can pick up the support / carry out an assessment.

Additional considerations for specific situations

Where contact is made via intermittent text/email/phone call that is cut off

In a text/email communication, we will seek to establish contact with the client by calling (if safe to do so). We then follow the process above. If we cannot establish contact at this stage, the worker will express their concern via the method of communication used by the client, advising that they will need to alert statutory services (e.g. if the client has a mental health worker, or by calling 111/999), encouraging the client to call us. If a helpline call ends where the client had been expressing an intention to end their life, and the workers have access to the client's phone number, they should attempt to call the client back to continue the conversation.

Where a client expresses a plan to end their life on leaving the session

In a session, if a client expresses intention and a plan to end their life upon leaving, but does not want us to pass this information on and will not tell us where they are going, we follow the above procedure and advise that we will be contacting emergency services with the information we have, and their current description. We will never obstruct a client from leaving the premises.

Additional guidance for therapists supporting an adult client who expresses an intention to end their life and has an imminent plan and they are known to the service, within a counselling session.

Where a client discloses within a therapy session that they have an intention to end their life, they have a plan and intend on acting on it, then we have a responsibility to act.

The therapist will communicate to the client that they are worried about them, and they should let the client know that they will escalate this to the Therapeutic Services Manager or the daytime emergency manager or evening on-call Manager, if the former is unavailable to take further action. The therapist will always seek to inform clients of this and involve them in the process, unless the therapist feels that passing on this information will significantly increase the level of risk.

If the client discloses that they have taken steps to end their life, assistance will be called. If the client does not want a third party to be involved, we still will contact the emergency services. Therapists are not able to accompany clients to Accident and Emergency.

If a client states they have a plan and will end their life after leaving the session, the therapist will (where possible) discuss a safety plan with the client. If the client remains sure they will end their life after leaving, the therapist should inform the client they will call emergency services and do so immediately. Where the risk of harm is not as imminent, the therapist will escalate to the relevant manager and they may then decide to contact a third party (e.g. GP or mental health worker) either with the client or when once they have left. If the risk of harm is high and immediate, we would let the client know that we are informing a third party and (if appropriate) seek their input as to how they would like to be involved. If the client chooses to leave the building, we would not prevent them from doing so.

[i] Understanding Suicide - Grassroots Suicide Prevention (prevent-suicide.org.uk)

[ii] Under the Care Act 2014, specific adult safeguarding duties apply to any adult (18 years or over) who: • has care and support needs and, • is experiencing, or is at risk of, abuse or neglect and, • is unable to protect themselves because of their care and support needs. An adult with care and support needs may be: • a person with a physical disability, a learning difficulty or a sensory impairment, • someone with mental health needs, including dementia or a personality disorder, • a person with a long-term health condition, • someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living. This is not an exhaustive list. In its definition of who should receive a safeguarding response, the legislation could also include people who are victims of sexual exploitation, domestic abuse and modern slavery. Sussex Safeguarding Adults Policy and Procedures (eastsussexsab.org.uk)

[iii] Understanding Suicide - Grassroots Suicide Prevention (prevent-suicide.org.uk)