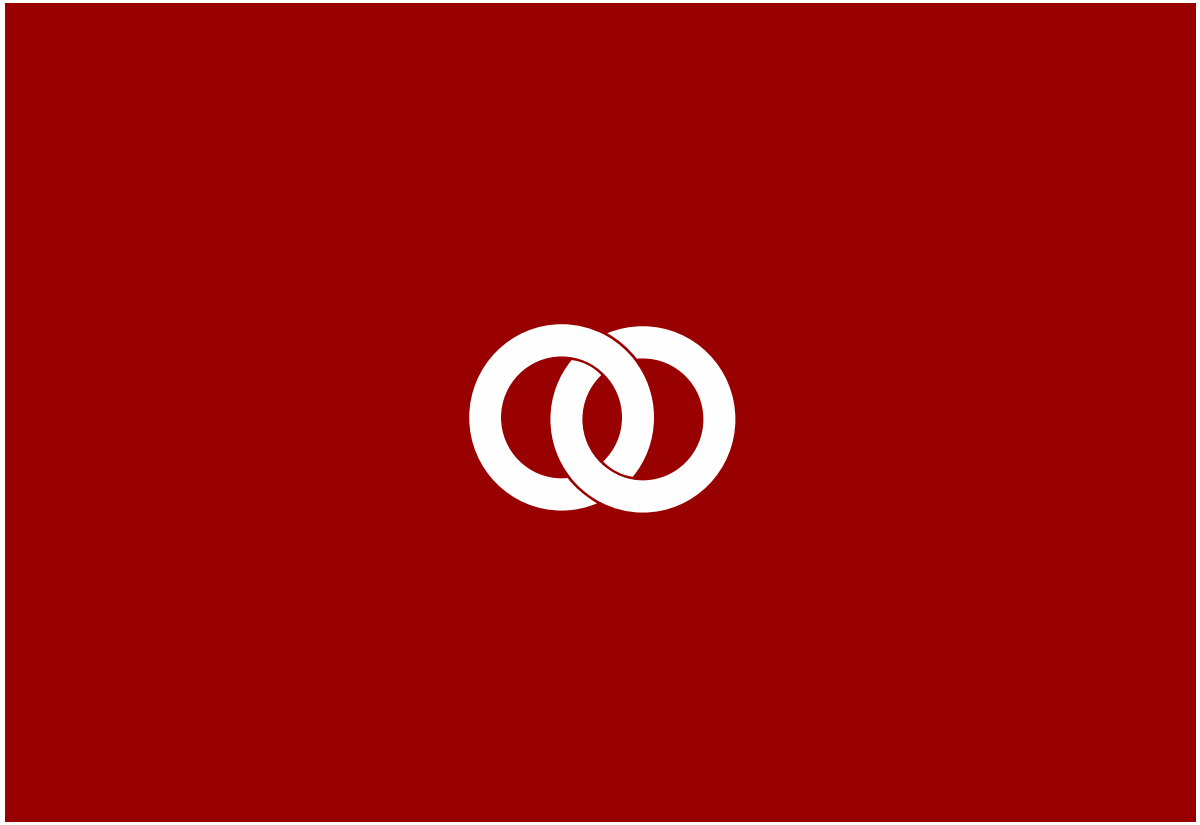

Working with Suicidal and Dangerous Clients: Legal, Ethical and Practical Issues

Michael Griffin, JD, LCSW CAMFT Staff Attorney

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It is not intended to serve as legal advice or to act as a substitute for independent legal advice.

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Workshop overview

- **The workshop will discuss key issues involved when working with suicidal clients,** including, but not limited to: Standards of care; The relevance of assessment to foreseeability of harm; identifying risk factors for suicide and undertaking "reasonable protective actions." Information from selected cases and relevant exceptions to confidentiality will also be discussed.
- **The workshop will discuss key issues involved when working with dangerous clients**, including, but not limited to: Standards of care; understanding the "duty to protect" based upon Tarasoff and Civil Code §43,92; the meaning of patient communication based upon the Ewing cases; understanding the "duty to report," based upon Welf.&Inst. Code §8100(b)(1) and §8105(c), and relevant exceptions to confidentiality

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Working with suicidal clients
Standards of care

- In all cases, including cases which concern a client who I at risk of suicide, a therapist is expected to meet the applicable "standard of care." The standard of care that is applicable depends on the facts and circumstances present in the case.
- The standard of care is based on the reasonable degree of skill, knowledge and care that is ordinarily exercised by other members of a practitioner's professional community, when practicing under similar circumstances.

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Working with suicidal clients
Standards of care

- **The standard of care is fact-driven: What is generally expected of a therapist who is treating a particular client, under the circumstances?**
- **In a malpractice trial, an "expert" witness may be used to help establish what the standard of care should be in the particular case.**

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Standard of care for health care professionals
Civil jury instruction §501

[A/An] [*insert type of medical practitioner*] is negligent if they fail to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [*insert type of medical practitioners*] would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as "the standard of care."

[You must determine the level of skill, knowledge, and care that other reasonably careful [*insert type of medical practitioners*] would use in the same or similar circumstances, based only on the testimony of the expert witnesses [including [*name of defendant*] who have testified in this case.] (instruction paraphrased for workshop)

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Working with suicidal clients
Scope of competency

- Scope of competency
- Every professional is required to practice within the scope of his or her competency. That would certainly apply in cases involving clients who are at risk of suicide. A practitioner's competency is based upon his or her education, training and experience.
- Competency is relevant to meeting standards of care. If a therapist is not able to competently treat an individual, it will be difficult for that therapist to meet the applicable standard of care. In other words, the therapist should possess the necessary education, training and experience to work with a given client/patient. This means that if your client is at risk of suicide, you are expected to be competent in working with such issues if you are working with that person.

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Working with suicidal clients
Scope of competency

- §1845. Unprofessional Conduct.
- As used in section 4982 of the code, unprofessional conduct includes, but is not limited to:
- Performing or holding oneself out as able to perform professional services beyond your competence as established by education, training and/or experience.
- (b) Permitting a trainee or associate under supervision to hold themself out as competent to perform professional services beyond the trainee's or associate's level of education, training and/or experience.

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Working with suicidal clients
Scope of competence
CAMFT Code of Ethics

- §5.11 Scope of Competence: Marriage and family therapists take care to provide proper diagnoses of psychological disorders or conditions and to not assess, test, diagnose, treat, or advise on issues beyond the level of their competence as determined by their education, training and experience. While developing new areas of practice, marriage and family therapists take steps to ensure the competence of their work through education, training, consultation, and/or supervision.

- §7.4 Competence of Supervisees: Marriage and family therapists ensure that the extent, quality and kind of supervision provided is consistent with the education, training, and experience level of the supervisee. Marriage and family therapists do not permit their students, employees, or supervisees to perform or to hold themselves out beyond their pre-licensed status or to perform professional services beyond their scope of competence.

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Working with suicidal clients
Foreseeability of harm

- When working with a client who is at risk of suicide, a key issue is whether the therapist is aware of facts from which they could reasonably conclude that a client is likely to harm themself in the absence of preventative measures.
- If the therapist is aware of foreseeable harm to their client, they would be expected to take reasonable protective measures. What is "reasonable," depends on the circumstances, and the needs of the client.
- A therapist cannot be expected to implement reasonable protective measures in a case where the potential suicide of their client was not reasonably foreseeable to that therapist.

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Working with suicidal clients
Foreseeability of harm- incidence data

- In 2022:
  - 49,000 people died by suicide
  - = 1 death every 11 minutes
  - 13 million people seriously thought about suicide
  - 3.8 million people made a. plan for suicide
  - 1.6 million people attempted suicide

Source: https://www.cdc.gov/suicide/index.html

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Working with suicidal clients
Foreseeability of harm- incidence data

Incidence data is relevant to the issue of foreseeability. In 2022, suicide was among the top 9 leading causes of death for people ages 10-64. Suicide was the second leading cause of death for people ages 10-14 and 25-34

- The suicide rate among males in 2022 was approximately four times higher than the rate among females. Males make up 50% of the population but nearly 80% of suicides.
- In 2021, more than a quarter (26.3%) of high school students identifying as lesbian, gay, or bisexual reported attempting suicide in the prior 12 months. This was five times higher than the prevalence among heterosexual students (5.2%).

source: https://www.cdc.gov/suicide/index.html

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Working with suicidal clients
Foreseeability of harm- incidence data

Age range	Crude rate per 100,000 population
85	23.02
75-84	20.26
65-74	15.97
55-64	1.69
45-54	19.24
35-44	18.73
25-34	19.04
15-24	13.62
10-14	2.36

source: https://www.cdc.gov/suicide/index.html

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Working with suicidal clients
Foreseeability of harm- incidence data

Method of suicide:

- Firearms are the most common method used in suicides. Firearms were used in more than 50% of suicides in 2022.

source: https://www.cdc.gov/suicide/index.html

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Working with suicidal clients
Foreseeability of harm

- What makes the possibility of suicide forseeable to a therapist?
- Therapists are not expected to foretell the future, read the client's mind, or control what the client does. The therapist is expected to competently assess the client, and determine whether there is a risk of suicide, based on that assessment.
- Competent assessment of the person's suicide risk requires, among other things, familiarity with risk factors for suicide.

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Working with suicidal clients
Identifying risk factors for suicide

- A therapist is not expected to ask every client: "Are you thinking of suicide?" But the therapist would be expected to ask such a question in some circumstances. How is that determined? The answer is related to the issue of ""Standards of Care." What would ordinarily be expected of a therapist who was working with the particular client?
- The therapist is expected to make reasonable efforts to evaluate their client, to determine the client's risk of suicide. Evaluating risk factors is an important aspect of evaluating suicidal risk.
- No single list of questions is suited for every person. Every therapist will employ their own style or approach to gathering information about a client and arriving at a diagnosis and treatment plan.

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Working with suicidal clients
Identifying risk factors for suicide

- Risk factors" for suicide, are facts from which the therapist could reasonably conclude that their client is at risk of harming themself in the absence of preventative measures.

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Working with suicidal clients
Identifying risk factors for suicide

- **Previous suicide attempts are associated with an increased risk for suicide, especially two or more attempts.**

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Working with suicidal clients
Identifying risk factors for suicide

- The presence of a major mood disorder is a significant risk factor for suicide.
- Borderline personality disorder and antisocial personality disorder are also associated with an increased risk of suicide

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Working with suicidal clients
Identifying risk factors for suicide

- There is evidence that clients face an elevated risk for suicide during the first year following an admission for inpatient psychiatric treatment, especially during the first few months after discharge.

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Working with suicidal clients
Identifying risk factors for suicide

- **A client's experience of hopelessness is a substantial risk factor for suicide.**

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Working with suicidal clients
Identifying risk factors for suicide

- **Social Isolation and the use of alcohol are recognized risk factors for suicide.**

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Working with suicidal clients
Identifying risk factors for suicide

- **A history of impulsivity is a risk factor for suicide.**

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Empirically informed risk-assessment

- **When assessing a person's overall risk for suicide, clinicians should gather information from multiple sources and not rely solely on the client's/patient's self-report. Additional information may be obtained from medical records, the patient's medical and mental health providers, friends, and family (where possible and appropriate).**
- **Suicide risk assessment should be an ongoing process, rather than an event which takes place at a particular time.**

- APA Textbook of Suicide Risk Assessment and Management Liza H. Gold, M.D. & Richard L. Frierson, M.D.
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Empirically informed risk-assessment

- Two significant indicators of suicide risk are suicidal thoughts and desire and defined plans and preparation for suicide. Approximately half of individuals who die by suicide do so on their first attempt.
- Suicidal ideation, in the absence of plans or preparations for suicide, suicidal ideation, *in itself*, does not indicate a high risk for suicide. The assessment of suicidal ideation should include suicidal thoughts and desire, as well as defined plans and preparations for suicide, including the availability and access to lethal means.

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Carol Chu, Kelly M. Klein, Jennifer M. Buchman-Schmitt, Melanie A. Hom, Christopher R. Hagan, and Thomas E. Joiner, "Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update", Journal of Clinical Psychology, Vol. 71(12), 1186–1200 (2015) (Available on EBSCO behavioral sciences database on the CAMFT website).

Empirically informed risk-assessment

- **Plans, methods and means for suicide**
- **The clinician should inquire about any methods and plans for suicide, including their specificity, the availability of means for suicide, and any preparation for suicide, such as acquiring or researching the means for suicide, obtaining materials for an attempt, or preparing a will.**
- **Access to the means of suicide (for example, the availability of a handgun) also increases risk.**

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Empirically informed risk-assessment

- Suicidal desire refers to the intensity, frequency, duration and preoccupation with, suicidal thoughts, including the content of such thoughts.

- Passive thoughts, such as: "I wish I was dead" indicate relatively lower risk, compared to frequent, high-intensity and active thoughts of killing oneself, such as: "I should buy a gun and shoot myself, or I should drive my car off of a cliff."

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Empirically informed risk-assessment

- Suicidal intent is related to the presence of a specific suicidal plan and the person's intention to carry out the plan.
- The existence of a plan for suicide is an obvious indictor of risk, but the specificity of the plan (for example, a plan to use a particular method, on a particular day) is an indicator of much greater risk.
- The availability of means to carry out the plan for suicide (like a plan to shoot oneself and having access to a firearm) is also pertinent to the determination of risk.
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Empirically informed risk-assessment

Thwarted belongingness and perceived burdensomeness are risk factors for suicide

"Thwarted belongingness" may be evident in social isolation and /or a person's unmet needs pertaining to relationships and social connections. While

- **"Perceived burdensomeness" is the view that one is a burden or a liability to others, such as co-workers, family or friends.**

Carol Chu, Kelly M. Klein, Jennifer M. Buchman-Schmitt, Melanie A. Hom, Christopher R. Hagan, and Thomas E. Joiner, "Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update", Journal of Clinical Psychology, Vol. 71(12), 1186–1200 (2015) (Available on EBSCO behavioral sciences database on the CAMFT website).

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Empirically informed risk-assessment

- **Non-suicidal self-injury:**

Evidence suggests that NSSI, (the direct, purposeful damage of one's own body tissues without any intent to die) is associated with elevated risk for future suicidal behavior. Current and past self-injurious behaviors should be considered when determining risk.

- **Precipitating factors**

Research indicates that the majority of suicidal acts are precipitated by a stressful life event. Stressors occurring within the past year)are generally considered to be greater risk factors for suicide, vs. chronic high stress.

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Empirically informed risk-assessment

- Hopelessness The belief that one's situation is unresolvable is one of the strongest predictors of future suicide attempts and death and support for this view has been found across populations.

- Psychopathology Psychiatric disorders, in general, are a risk factor for suicide-related behaviors in youth, adult, and elderly populations. Mood and anxiety disorders (especially depressive and bipolar disorders), eating disorders, impulse-control disorders, psychoses, substance use disorders, and personality disorders, are associated with the highest risk for suicide and suicidal behavior

Carol Chu, Kelly M. Klein, Jennifer M. Buchman-Schmitt, Melanie A. Hom, Christopher R. Hagan, and Thomas E. Joiner, "Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update", Journal of Clinical Psychology, Vol. 71(12), 1186–1200 (2015) (Available on EBSCO behavioral sciences database on the CAMFT website).

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Empirically informed risk-assessment

- Impulsivity Suicidal risk is increased where the client has problems with impulsivity, in spite of the fact that suicidal behavior itself is generally premeditated rather than an impulsive act
- Agitation (outward behavioral signs of over-arousal, such as pacing, hand-wringing, etc.) is often considered to be an indicator of imminent suicide risk and elevated symptoms of agitation are associated with an increased risk for suicide.

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Empirically informed risk-assessment

Marked Irritability Significant irritability is associated with a possible increased risk for suicide. A related issue is that a person's increased irritability may interfere with their social support, increase their isolation from others, and potentially increase their risk of suicide.

- Social Withdrawal Marked changes in social withdrawal from routine activities is often observed in the days, weeks and months leading up to a person's suicide.

- Severe Weight Loss Significant changes in a person's weight, or appetite, should be considered when evaluating a person's risk for suicide.

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Empirically informed risk-assessment

Severe Affective states, when perceived by the client as intolerable and uncontrollable, are potential indicators of imminent suicide risk. (e.g., severe, uncontrollable anxiety, rage, hopelessness, guilt, etc.)

Sleep Disturbances, including insomnia, nightmares, and nighttime panic attacks, are common symptoms associated with suicidal acts

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Working with suicidal clients
Reasonable preventative measures

If a therapist becomes aware that their client is at risk of suicide, courts have generally held that the therapist has a duty to take "reasonable" or "appropriate" steps to attempt to prevent the client's suicide.

What may be considered as "reasonable," depends on the facts and circumstances of the case. There is not a list of actions or interventions which can be uniformly applied in all circumstances with all clients.

A therapist should strive to implement a course of action, which they consider to be reasonable and appropriate for their client, at that point in time. It is important to document the rationale for such actions.

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Working with suicidal clients
Reasonable preventative measures may include, but are not limited to:

- Facilitating the client's hospitalization
- Consulting with the client's psychiatrist
- Arranging for the client to be evaluated by a psychiatrist
- Asking the client to agree to a no-self harm agreement
- Attempting to increase the degree of social support available to the client
- Involving a friend or family member in the client's treatment
- Increasing the intensity of the treatment, such as increasing the number of sessions, or the amount of overall contact with the client.

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Working with suicidal clients
Reasonable preventative measures

- **Obtaining a client's prior treatment record may constitute a reasonable preventive measure.**
- **It could be argued that the prior treatment record may have helped the therapist to become aware of important diagnostic information, or reasonable protective actions.**

- Jablonski v. United States, (1983) 712, F.2d 391

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Elements of effective treatment

- **Research has shown that targeting and treating suicidal ideation and behaviors, independent of diagnosis, may have significant benefit in lowering suicidal risk.**
- **When a client/patient is at risk of suicide, it is generally recommended that intervention and treatment be provided that is intended to directly and specifically target the potential suicidality.**
- **For example: Are there specific situations that seem to be associated with increased suicidal ideation?**

- VA/DoD CLINICAL PRACTICE GUIDELINE FOR ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK FOR SUICIDE

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The "Zero Suicide" model

- In a project funded by NIMH grant, the National Action Alliance for Suicide Prevention created the "Zero Suicide Model," (aka: the Assess, Intervene and Monitor for Suicide Prevention Model), founded upon evidence- based practices derived from a 10-year systematic review of findings in suicide prevention.
- The authors summarized key areas of research and attempted to translate the information into a treatment protocol.

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The "Zero Suicide" model, Cont'd

- The Zero Suicide model requires therapists to engage in:
  - Ongoing risk screening and assessment,
  - Collaborative safety planning,
  - Lethal means reduction,
  - Consistent engagement of the client, and,
  - Providing support during high-risk periods.

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The "Zero Suicide" model, Cont'd

- The Zero Suicide model involves ten steps for clinical management which are intended to be incorporated into standard clinical practice. They are not intended to be followed in a rote, sequential manner, but rather integrated into the person's treatment plan.
- These steps are intended to improve suicide risk assessment, and utilize brief interventions to increase safety, teach coping strategies to the client, and stress ongoing contact and monitoring of high-risk individuals during high risk periods.

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The "Zero Suicide" model, Cont'd

- A clinician cannot assume that the client's mental state is stable from moment to moment or day to day.
- For example, research has found that suicidal ideation, hopelessness, burdensomeness and loneliness may vary considerably over the course of hours and days.
- Evidence-based best practices stress the importance of managing the fluctuation of suicide risk over time.

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The "Zero Suicide" model, Cont'd

- Step 1: Inquire explicitly about suicidal ideation and behavior, past and present. The first step in assessing suicide risk at any given moment is to explicitly ask whether the person is having any suicidal thoughts.
- The clinician should not assume that the client is not suicidal if they don't report it. By neglecting to ask, the client might feel that the clinician doesn't care or doesn't really want to know.

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The "Zero Suicide" model, Cont'd

- **Step 1: Inquire about suicidal Ideation and behavior,(cont'):**
- **Determine the presence or absence of a suicide plan, which includes probing for detailed information about specific plans for suicide, including any steps which may have been taken toward enacting those plans.**
- **Determine the patient's belief about the lethality of the method, which may be as important as the actual lethality of the method.**

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"Assessing and Treating Suicidal Behaviors, A Quick Reference Guide," by the American Psychiatric Association) (available on EBSCO on the CAMFT website) recommends that a clinician:

The "Zero Suicide" model, Cont'd

- **Step 1: Inquire about suicidal Ideation and behavior, (cont'd):**
- **Determine the conditions under which the patient would consider suicide (e.g., divorce, going to jail, housing loss)**
- **Inquire about the presence of a firearm in the home or workplace. If a firearm is present, discuss with the patient or a significant other the importance of restricting access to, securing, or removing this and other weapons.**

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The "Zero Suicide" model, Cont'd

- **Step 2**: **Identify risk factors for suicide**

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The "Zero Suicide" model, Cont'd

- Step 3: Implement and Maintain Continued Focus on Safety
- Since suicidal urges fluctuate, an evidence-based clinical approach to suicide prevention necessitates ongoing assessment and continued focus on safety.
- Don't assume that what the client says today is a reflection of how they may feel tomorrow.
- Clinicians should explicitly inquire about suicidal thoughts, urges, or behaviors at each contact, and revisit and update plans for staying safe.

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The "Zero Suicide" model, Cont'd

- Step 4: Develop a collaborative safety plan for managing suicidality.
- A collaborative safety plan may include:
  - identifying warning signs of increased risk for suicide, and, identifying and implementing specific coping skills, such as:
    - People to use for support;
    - Activities and places to use for distraction;
    - Specific resources, such as professionals to contact for help, and
    - Specified steps to take for ensuring safety.

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The "Zero Suicide" model, Cont'd

- Step 5: Initiate and practice the use of coping strategies
- For example:
  - Help the client to recognize when it is important to use coping strategies
    - Such as when they experience increased anxiety, depression, isolation, feeling ashamed or worthless, etc.
  - Help the client to identify people who are sources of help or support: (uncle, cousin, roommate, therapist, crisis hotline, friends, etc.)

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The "Zero Suicide" model, Cont'd

- **Step 6: Help the client to make the environment safe**
- **Such as:**
  - **Removing lethal means of self-harm (guns, knives, etc.)**
  - **Limit the amount of medication available, if possible.**
  - **Remove alcohol and drugs from the premises**

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The "Zero Suicide" model, Cont'd

- Step 7: Increase availability to the Client
- The Zero Suicide model recommends increased therapeutic contact during periods of suicidal crises.
- This can take the form of increased number of appointments, and availability for between session check-ins by phone or e-mail.

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The "Zero Suicide" model, Cont'd

- **Step 8: Initiate Increased Monitoring During Periods of Highest Risk**
- **Periods following a suicide attempt or suicide crisis, discharge from inpatient hospitalizations, and transfer from higher to lower level of care, are well-known high-risk times.**
- **The client's particular history may reveal information about other "high risk" times in their life, such as anniversaries of losses, job loss or change, financial problems, relationship breakups or periods of increased conflict, etc.**

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The "Zero Suicide" model, Cont'd

- **Step 9: Involve family and other social supports**
- **With the client's permission, a therapist may involve members of the individual's support network to create a safety net.**
- **With the client's permission, family or friends may monitor the client during high-risk periods, check-in regularly with the client to provide support, or reach out to the therapist when necessary.**

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The "Zero Suicide" model, Cont'd

- **<u>Step 10</u>: <u>Collaborate with other professionals</u>**
- **A therapist may take a team approach with other health care professionals and reach out to other members of the team (family physician, psychiatrist) when necessary to coordinate safety plans.**

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The "Zero Suicide" model, Cont'd

- For information about the Zero Suicide model, see the article available on the EBSCO behavioral sciences database, on the CAMFT website, by Beth Brodsky, Aliza Spruch-Feiner, and Barbara Stanley, "The Zero-Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care," Frontiers of Psychiatry, Feb., 2018, Vol. 9, article 33, www.frontiersin.org.

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The importance of documentation

- Documentation is paramount in cases which involve the treatment of suicidal patients.
- The clinical record allows the therapist to demonstrate that:
- A competent assessment was conducted
- A reasonable effort was made by the therapist to identify risk factors, and,
- The therapist attempted to institute reasonable protective measures in keeping with their assessment.

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The importance of documentation cont'd

- The treatment record should reflect the degree to which a client was, or was not, cooperative with the therapist's efforts.
- The therapist's clinical documentation should convey that the standard of care has been met.
- 4982(v), Business & Professions Code: The failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered is unprofessional conduct.

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The importance of documentation, Cont'd
CAMFT Code of Ethics

- §5.3 Client/Patient Records: Marriage and family therapists create and maintain client/patient records consistent with sound clinical judgment, standards of the profession, and the nature of the services being rendered.

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Working with suicidal clients
The use of "no-suicide contracts"

- The use of no-suicide contracts by clinicians working with high-risk clients is common practice. Also referred to as "no-self harm" agreement, a no-suicide contract is an agreement between the clinician and their client, wherein the client agrees not to harm themself and to seek help from the therapist or other identified person, when they experience suicidal urges.
- Despite their prevalent use, there is little empirical evidence that no-suicide contracts are effective in preventing suicide, in the absence of other treatment efforts.

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Working with suicidal clients

- **Bellah v. Greenson , (1978)81 Cal. App. 3d 614**
- **This case provides an example of what is generally expected of a therapist when working with a suicidal client. The parents of an adolescent girl who died by suicide brought a lawsuit against their daughter's former psychiatrist, wherein they alleged that he was negligent in the care of her daughter because he failed to use reasonable care to prevent her suicide. However, the girl's parents also contended that Dr. Greenson was negligent, because he failed to inform them of the fact that their daughter was engaging in high-risk behavior during the time that she was in treatment.**

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Working with suicidal clients
Bellah v. Greenson

- The Court of Appeal agreed that Dr. Greenson had a duty to exercise reasonable care in his treatment of the girl; meaning that he was expected to take "appropriate preventive measures" concerning her risk of suicide.
- The court did not agree with the plaintiff's contention that Dr. Greenson had a specific duty to disclose his client's confidential information to her parents.
- The court recognized that, if every therapist was faced with a broad mandate to disclose confidential information regardless of whether it was clinically appropriate to do so, the disclosure itself could result in the rupture of the therapist-client relationship and potentially increase the client's risk of suicide.

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Working with suicidal clients
Relevant exceptions to confidentiality

- § 56.10., Civil Code
- (19) The information may be disclosed, consistent with applicable law and standards of ethical conduct, by a psychotherapist, as defined in Section 1010 of the Evidence Code, if the psychotherapist, in good faith, believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

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Working with suicidal clients
Relevant exceptions to confidentiality

- 56.10., Civil Code
- (c)(1) A provider of health care may disclose medical information to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient.

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Relevant resource

"Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update," by Carol Chu, et.al., Journal of Clinical Psychology, 71:1186-1200, (2015)

Available via the EBSCO Behavioral Sciences portal on the CAMFT website.

The authors discuss key issues that should be assessed, including, previous suicidal behavior, current suicidal symptoms, such as suicidal ideation and the specific content of such ideation, plans and means for suicide, suicidal desire (defined as the frequency, intensity, duration and preoccupation with suicidal thoughts), the degree of suicidal intent, the individual's thwarted belongingness, perceived burdensomeness and capability for suicide, past self-injurious behaviors, precipitating stressors, psychopathology (especially mood disorders, psychoses, substance use disorders and personality disorders), impulsivity, agitation, marked irritability, social withdrawal, severe weight loss, severe affective states, particularly when perceived as intolerable and uncontrollable, feelings of abandonment and other factors.

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Relevant resource

The Suicidal Patient: Clinical and Legal Standards of Care, Third Edition, by Bruce Bongar, PhD and Glenn R Sullivan, PhD, APA Press (also available on Amazon)

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Relevant EBSCO Article

"Advances in the Assessment of Suicide Risk," by Craig J. Bryan and M. David Rudd, Journal of Clinical Psychology In Session, Vol. 62(2), 185-200, (2006)

Authors offer a model of "risk assessment," focusing on categories that have empirical support, including, predisposition to suicidal behaviors; identified precipitants/stressors; symptomatic presentation; presence of hopelessness; the nature of suicidal thinking; previous suicidal behavior; impulsivity and self-control; and protective factors. The authors stress the need to try to increase the available protective factors along with decreasing risk factors. For example, increasing social contact and decreasing isolation.

Available on the CAMFT website via EBSCO, Behavioral Sciences Collection. Article is one example of research that is available via EBSCO.

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Working with Dangerous Clients

- Tarasoff v. Regents of Univ. of Calif., (1976) 17 Cal.3d at p. 431.
- Civil Code, §43.92
- Civil Jury Instruction , §503A
- Civil Jury Instruction , §503 B
- Ewing v. Goldstein, Ph.D. (2004)120 Cal.App.4th 807
- Ewing v. Northridge Hospital Center, (2004) 120 App.4th 807
- Welfare & Institutions Code, §8100(b)(1)
- Welfare & Institutions Code, §8105(c)

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The Tarasoff case

- The Tarasoff case is based on the 1969 murder of a student at UC Berkeley named Tatiana Tarasoff. Prosenjit Poddar, a graduate student at Berkeley, met Tatiana at a folk dancing class on campus. They dated briefly, but Poddar became obsessed with Tatiana, began stalking her and she broke off the relationship. Poddar began psychological counseling at the university clinic. Poddar's therapist, Dr. Lawrence Moore, became concerned when Poddar confessed his intention of killing Tatiana Tarasoff (he never actually named her in the sessions, but identifying Tarasoff was apparently not very difficult). Dr. Moore advised Poddar that, if the death threats continued, he would have no choice but to have Poddar hospitalized. Although Poddar was briefly hospitalized at a University hospital, he was released after a short in-patient stay. Dr. Moore then wrote a letter to campus police saying that Poddar was dangerous and advised them of his death threats toward Tatiana. Campus police interviewed Poddar but when he denied making any death threats and assured police that he would stay away from Tarasoff, he was released. Despite his promise, Poddar continued to stalk Tatiana and eventually stabbed her to death at her home. No one ever warned Tatianna of the fact that Poddar had stated his intention to kill her.

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Working with dangerous clients
Tarasoff v. Regents of Univ. of Calif.

The Tarasoff case came to be known as the case that established a "duty to warn," but it is more accurate to say that **the duty created by Tarasoff is a "duty to take reasonable care to protect the intended victim."**

It should be noted that a therapist may discharge the **"duty to protect**" under Tarasoff, by taking actions other than warning the victim.

The specific facts and circumstances determine whether the therapist's action is sufficient to discharge the duty. In other words, did the therapist take reasonable actions to protect the person under the circumstances?

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Working with dangerous clients
Tarasoff v. Regents of Univ. of Calif.

The Tarasoff court opined:

"When a therapist determines, or pursuant to the standards of his profession should determine, that his **patient presents a serious danger of violence to another,** he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances." **Tarasoff v. Regents of Univ. of Calif., (1976) 17 Cal.3d at p. 431.**

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Working with dangerous clients
Tarasoff v. Regents of Univ. of Calif.

A "Serious Danger of Violence"

The Tarasoff case contains the phrase, "a serious danger of violence," not, "a danger of serious violence." There isn't a requirement that the patient is threatening murder/homicide for a duty to exist.

The Existence of an Imminent Threat

The use of the phrase "serious danger of violence" is generally interpreted to mean that the threat must be "imminent" in order for the duty to arise.

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Working with dangerous clients
Tarasoff v. Regents of Univ. of Calif.

Reasonably Identifiable Victim or Victims

A "Tarasoff duty" does not exist when there are nonspecific threats made against non-specified persons. If the patient expresses a threat, it must concern a reasonably identifiable victim or victims.

The duty arises as a result of actions taken by the therapist's patient, not actions taken by some other person.

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43.92 Civil Code- Set forth a "Duty to Protect" This statute clarified and limited the duty arising from Tarasoff.

a.) **There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to protect from a patient's threatened violent behavior or failing to predict and protect from a patient's violent behavior except if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.**

b) **There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist who, under the limited circumstances specified in subdivision (a),discharges his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.**

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§43.92 Ca. Civil Code- set forth a "duty to protect"

Civil Code section 43.92 was enacted to limit the liability of psychotherapists under Tarasoff. (Barry v. Turek (1990) 218 Cal.App.3d 1241, 1244–1245 [267 Cal.Rptr. 553].)

Under §43.92, a therapist is not liable for the physical violence of their client, unless the client communicated a serious threat of physical violence against a reasonably identifiable victim.

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Working with dangerous clients Patient must communicate concrete threat of harm

- Calderon v. Glick, 131 Cal.App.4th 224 (2005)
- The Court ruled that therapists had no duty to warn/protect where the patient did not communicate a concrete threat of physical violence to the patient's therapists.

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Working with dangerous clients Patient must communicate concrete threat of harm

Calderon v. Glick, 131 Cal.App.4th 224 (2005) (cont'd)

The patient in this case shot and killed three members of his former girlfriend's family and wounded two more. He later died by suicide.

Surviving family members sued the providers, alleging that they failed to warn/protect them of the danger posed by the patient in this case.

Providers testified that they had never received a communication from the patient which expressed the intention to harm anyone.

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Working with dangerous clients Patient must communicate concrete threat of harm

- Calderon v. Glick, 131 Cal.App.4th 224 (2005) (cont'd)
- In this case, the court did not find that the providers owed a duty to the family members. The provider's documentation was very clear: The psychiatrist, Dr. Glick claimed that every time he saw the patient, he asked the patient if he intended to harm any one and the patient consistently responded that the did not.
- Dr. Wright testified, "I looked at (patient) straight in the face clearly and I said, "Do you have any intention to hurt your former girlfriend…and he said no… I concluded that at that time he was not a risk."

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Working with dangerous clients credible threat of serious physical violence

Calderon v. Glick, 131 Cal.App.4th 224 (2005) (cont'd)

The Court clarified the duty to protect, as expressed in Civil Code section 43.92:

"Section 43.92 strikes a reasonable balance in that it does not compel the therapist to predict the dangerousness of a patient. Instead, it requires the therapist to attempt to protect a victim under limited circumstances, even though the therapist's disclosure of a patient confidence will potentially disrupt or destroy the patient's trust in the therapist.

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Working with dangerous clients
Patient must communicate concrete threat of harm

Turner v Rivera
Unpublished decision
US Court. of Appeals
Feb. 2, 2021

Psychiatrist Dr. Rivera informed law enforcement and the employer of patient Ronald Turner that Mr. had threatened to kill his supervisor.

Ronald Turner did not ever make such a threat. Dr. Rivera said she made the report to "err on the side of caution."

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Working with dangerous clients Patient must communicate concrete threat of harm

Turner v Rivera (Cont'd)

During a meeting at the VA, a social worker asked Turner, hypothetically, "What would you do if you wanted to kill your supervisor?"

Turned said he did not intend to harm his supervisor, but hypothetically, if he was going to do so, he would drive to the work setting and shoot him. Turner expressly denied any such intent and said he did not own a gun.

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Working with dangerous clients Patient must communicate concrete threat of harm

- **Turner v Rivera** (Cont'd)

Nine days after meeting with the VA social worker, Mr. Turner met with Dr. Rivera one time for an hour. During that meeting, he told her about the hypothetical and again stated that he did not intend to harm his supervisor.

In her progress notes, Dr. Rivera wrote that Turner was "a low-moderate risk of harming others" and that he was "not a serious risk." Dr. Rivera called the social worker to ask about his impression of Turner. The social worker confirmed that he did not think Turner posed a threat to his supervisor, The next day, Dr. Rivera called Mr. Turner, and with his wife on speakerphone, said that she intended to inform law enforcement and Turner's supervisor that Turner had threatened the supervisor's life, which she did. Turner was fired.

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Working with dangerous clients Patient must communicate concrete threat of harm

Turner v Rivera (Cont'd)

At trial, Turner pursued a claim against Dr Rivera for negligence, but the appeals court said that he was not limited to a negligence claim because Dr. Rivera engaged in an intentional breach of Turner's confidential information when she shared his private information.

Court of Appeal said that Dr. Rivera was not entitled to the affirmative defense provided by Civil Code 43.92 because the elements described in that statute were not met.

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Working with dangerous clients
Civil jury instruction 503 A. Psychotherapist's duty to protect intended victim from patient's threat

Plaintiff claims that defendant's failure to protect plaintiff/decedent was a substantial factor in causing injury to plaintiff/death of [decedent]. To establish this claim, plaintiff must prove the following:

1.That defendant was a psychotherapist;

2.That patient was defendant's patient;

3.That patient] communicated to [defendant] a serious threat of physical violence;

4.That plaintiff/decedent was a reasonably identifiable victim of patient's threat;

5.That patient injured plaintiff/killed [decedent];

6.That name of defendant failed to make reasonable efforts to protect plaintiff/decedent; and

7.That defendant's failure was a substantial factor in causing plaintiff's injury/the death of [decedent].

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Civil jury instruction 503 B Affirmative defense- Psychotherapist's communication of threat to victim and law enforcement.

Defendant is not responsible for plaintiff's injury/death if defendant proves that they made reasonable efforts to communicate the threat to plaintiff/decedent and to a law enforcement agency.

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Working with dangerous clients
The meaning of "patient communication"

- Ewing v. Goldstein, Ph.D. (2004)120 Cal.App.4th 807
- Ewing v. Northridge Hospital Center (2004)120 App.4th 80
- These cases arose from a murder-suicide that occurred in the Los Angeles area on June 23, 2001. Gene Colello, a former member of LAPD shot and killed Keith Ewing, who was the boyfriend of Collelo's former girlfriend, Diana Williams. He then turned the gun on himself.

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Working with dangerous clients
The meaning of "patient communication"

- In 1997, Gene Colello began therapy with David Goldstein, Ph.D. In 2001, Colello learned that his ex, Diana Williams, was romantically involved with Keith Ewing.
- Dr. Goldstein asked Colello if he was suicidal, and Colello admitted to thinking about suicide. Dr. Goldstein discussed voluntary hospitalization with Colello and obtained permission from Colello to speak with Colello's father, Victor Colello.
- Victor Colello informed Dr. Goldstein that his son had asked him for a gun so that he could shoot himself. When Victor Colello refused to honor his son's request, Colello reportedly told his father that he intended to get a gun and kill Williams' new boyfriend (Keith Ewing) and then himself. Victor Colello informed Dr. Goldstein about this. Dr. Goldstein asked Victor Colello to take his son to Northridge Hospital Medical Center, which he did.

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Working with dangerous clients
The meaning of "patient communication"

- At Northridge hospital, Art Capilla, LCSW assessed Gene Colello. Victor Colello alleges that he informed Capilla about the threat that his son had made regarding Keith Ewing. According to the record, Capilla intended to have Colello involuntarily hospitalized, but fearful of the effect such an action would have on his career as a policeman, Colello agreed to voluntarily enter Northridge. Colello came under the care of Dr. Gary Levinson, a staff psychiatrist. Dr. Levinson did not believe that Colello was suicidal, and despite Dr. Goldstein's objections, discharged Colello from Northridge. No one warned Keith Ewing that Colello was dangerous to him, and one day after being discharged from Northridge, Colello murdered Keith Ewing.

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Working with dangerous client
The meaning of "patient communication"

- The Ewing family filed a wrongful death action for professional negligence against Dr. Goldstein, and a wrongful death action for professional negligence against Northridge hospital.
- Dr. Goldstein contended that he could not be held liable for failing to warn Ewing about the danger that Colello posed to Ewing, because his patient, Gene Colello had not directly communicated to Goldstein that he intended to harm Ewing. The Ewing family countered that Colello's interactions with Dr. Goldstein made him aware of the threat that Colello posed to Ewing. Therefore, they argued, Goldstein should have warned Ewing.
- The trial court sided with Dr. Goldstein, and the decision was appealed .

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Working with dangerous clients
The meaning of “patient communication”

- The Court of Appeal examined the question of whether a communication from a patient's family member, made for the purpose of advancing the patient's therapy, is a "patient communication" within the meaning of Civil Code § 43.92.
- The Court of Appeal, in *Ewing* I, and, in *Ewing* II, held that communications from family members are “patient communications”within the meaning of Civil Code §43.92.
- Therefore, a communication from a patient's "family member" to the patient's therapist about a serious threat of physical violence by the patient, against a reasonably identifiable victim, may create a duty to protect the intended victim.

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Working with dangerous clients
The "Duty to Report"

- In addition to Tarasoff, and §43.92 of the Civil Code, which set forth a "Duty to Protect," there is also a "Duty to Report" in California.
- Under Welfare and Institutions Code, §8105(c), a licensed psychotherapist shall report to a local law enforcement agency, within 24 hours, the identity of a person (patient) who is subject to subdivision (b) of §8100 of the Welfare and Institutions Code.
- A patient is subject to §8100(b), if he or she communicates to his or her therapist, a serious threat of physical violence against a reasonably identifiable victim or victims.

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Working with dangerous clients
The "Duty to Report"

What does "local law enforcement" mean?

§8105(c) of the Welfare and Institutions Code does not explain what is specifically meant by "local law enforcement."

Consequently, it isn't possible to say whether it is better to report to the jurisdiction where the patient resides, or to the jurisdiction where the intended victim is.

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Working with dangerous clients
The "Duty to Report"

- **After the therapist makes a report to local law enforcement, information will be sent to the Department of Justice who will communicate with the patient about the fact that they cannot possess firearms for a period of five years.**
- **The patient may petition the court for an order permitting them to possess firearms at an earlier date.**

- *See*, Jensen, David, JD, "Your Duty to Report Serious Threats of Violence," *The Therapist*, Jan. 2015

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Working with dangerous clients
The "Duty to Report"

Welfare & Institutions Code, §8100(b)(1)

A person shall not have in his or her possession or under his or her custody or control, or purchase or receive, or attempt to purchase or receive, any firearms whatsoever or any other deadly weapon for a period of five years if, on or after January 1, 2014, he or she communicates to a licensed psychotherapist, as defined in subdivisions (a) to (e), inclusive, of Section 1010 of the Evidence Code, a serious threat of physical violence against a reasonably identifiable victim or victims. The five-year period shall commence from the date that the licensed psychotherapist reports to the local law enforcement agency the identity of the person making the communication.

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Working with dangerous clients
The "Duty to Report"

- The Phrase "Licensed Psychotherapist"
- Welfare and Institutions Code §8105(c) applies to "licensed psychotherapists" but what about pre-licensed psychotherapists?
- Because pre-licensed therapists provide therapy to patients who make threats, the Duty to Report would seem to apply to them as well as to licensed psychotherapists, in spite of the fact that unlicensed practitioners are not specifically named in the statute.
- Pre-licensed therapists who have clients who express threats of harm should always inform their supervisors. The Duty to Report could simply be fulfilled by supervisors on behalf of all concerned, or a licensed supervisor and their supervisee may consider jointly contacting the police to file the report.
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The Importance of Documentation

- **Progress notes help to demonstrate the therapist's efforts to evaluate whether an individual intended to harm someone.**
- **When applicable, the therapist should document the fact that their client denied having the intent to harm someone.**
- **Therapists should not be reluctant to ask the client specific questions about their intent to do harm.**
- **Progress should be used to demonstrate that a therapist was aware of and made reasonable efforts to satisfy their duty to protect and the duty to report.**

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The Value of Consultation

- **Therapists have a very challenging occupation. It is hard to overstate the value of consultation , especially in circumstances where there is a risk of self-harm, or when the client poses a threat of harm to others.**
- **Therapists are required to be competent, but they are not expected to know everything. Consultation provides information that may not otherwise be known to the therapist.**
- **Seeking consultation is an example of the therapist taking steps which reflect <u>that the therapist was attempting to meet the relevant standard of care</u>.**

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Thank you!

Questions? You are welcome to contact CAMFT legal staff at:

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