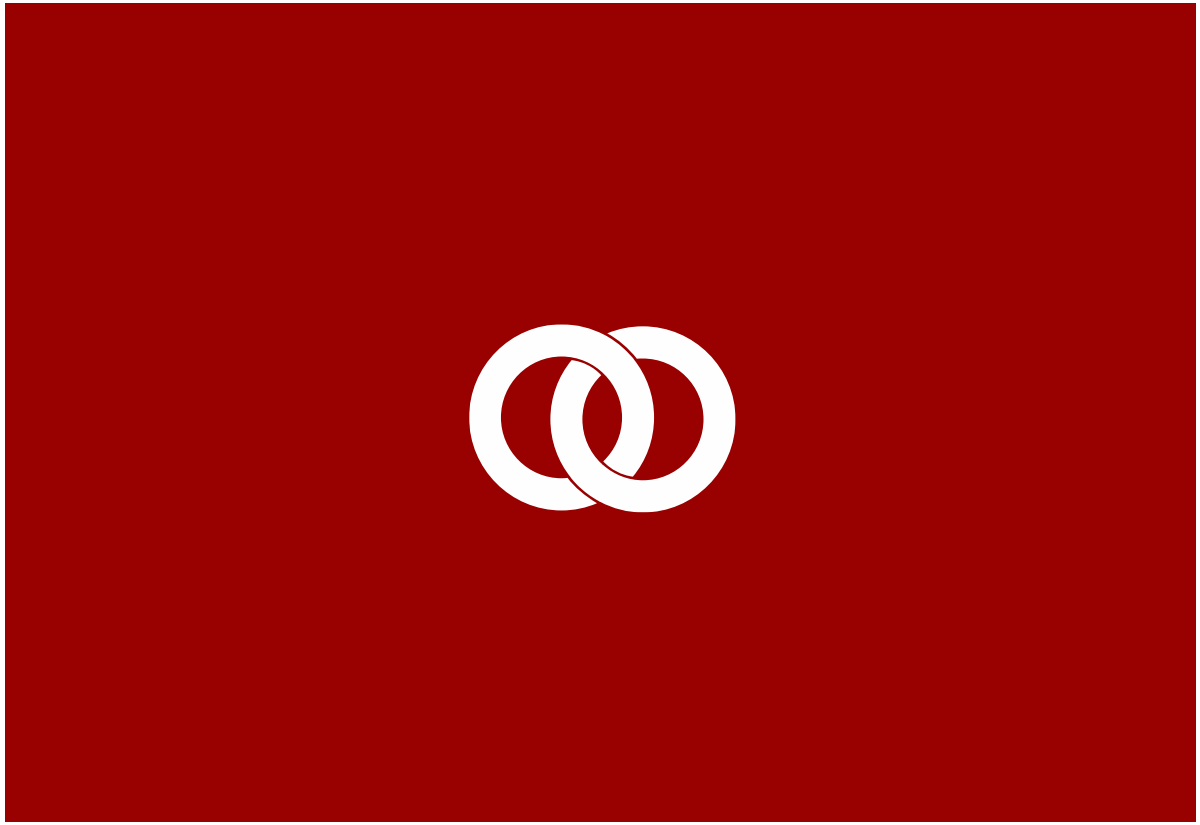


Working with Suicidal Clients: Legal, Ethical and Practical Issues

Michael Griffin, ESQ., LCSW CAMFT Staff Attorney

Disclaimer

The information provided in this workshop is for educational purposes only.

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

Workshop overview

- The workshop will discuss various key issues that are applicable when working with clients who are at risk of suicide.
- Topics to be addressed include:
- The incidence of suicide: Statistical and demographic data
- Avoiding liability: Negligence and standard of care
- Empirically based assessment: “risk factors” and “protective factors”
- Implications for treatment: “Reasonable preventive measures”

Workshop overview

- Evidence based suicide prevention: The “Zero Suicide Model”
- Youth suicide: incidence, demographic data, risk factors and protective factors
- Relevant exceptions to confidentiality: Permitted disclosures
- Relevant ethical standards
- Issues involving documentation
- Resources for clinicians

Business & Prof. Code §4980.396 Required coursework or supervised experience: Suicide Risk Assessment and Intervention

- **(a) On or after January 1, 2021, an applicant for licensure as a marriage and family therapist shall show, as part of the application, that he or she has completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention.**
- **This requirement shall be met in one of the following ways:**
- **(1) Obtained as part of his or her qualifying graduate degree program.** To satisfy this requirement, the applicant shall submit to the board a written certification from the registrar or training director of the educational institution or program from which the applicant graduated stating that the coursework required by this section is included within the institution's curriculum required for graduation at the time the applicant graduated, or within the coursework that was completed by the applicant.

Business & Prof. Code §4980.396
Required coursework or supervised experience:
Suicide Risk Assessment and Intervention

(2) Obtained as part of his or her applied experience. Applied experience can be met in any of the following settings: practicum or associateship that meets the requirement of this chapter, formal postdoctoral placement that meets the requirements of Section 2911, or other qualifying supervised experience. To satisfy this requirement, the applicant shall submit to the board a written certification from the director of training for the program or primary supervisor where the qualifying experience has occurred stating that the training required by this section is included within the applied experience.

(3) By taking a continuing education course that meets the requirements of Section 4980.54. To satisfy this requirement, the applicant shall submit to the board a certification of completion.

(b) As a one-time requirement, a licensee prior to the time of his or her first renewal after January 1, 2021, or an applicant for reactivation or reinstatement to an active license status on or after January 1, 2021, shall have completed a minimum of six hours of coursework or applied experience under supervision in suicide risk assessment and intervention, using one of the methods specified in subdivision (a). (c) Proof of compliance with this section shall be certified under penalty of perjury that he or she is in compliance with this section and shall be retained for submission to the board upon request.

Definitions

- **Suicide** is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior.
- **A suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.
- **Suicidal ideation** refers to thinking about, considering, or planning suicide.

https://www.nimh.nih.gov/health/statistics/suicide.shtml

The incidence of suicide

- **In 2019, 12.0 million adults aged 18 or older reported having serious thoughts of suicide, and 1.4 million adults attempted suicide during the past year.**

- National Institute of Mental Health **https://www.nimh.nih.gov/health/statistics/suicide.shtml#part_154973**

The incidence of suicide

- Suicide statistics
- Suicide is the 10th leading cause of death in the US
- In 2018, 48,344 Americans died by suicide
- In 2018, there were an estimated 1.4M suicide attempts
- The suicide rate in 2018 was 14.2 per 100,000 individuals.
- American Foundation for Suicide Prevention (AFSP)

The incidence of suicide

- The rate of suicide is highest in middle-aged white men.
- In 2018, men died by suicide 3.56 times more often than women.
- On average, there are 132 suicides per day.
- White males accounted for 69.67% of suicide deaths in 2018.
- In 2018, firearms accounted for 50.57% of all suicide deaths.

- American Foundation for Suicide Prevention (AFSP)

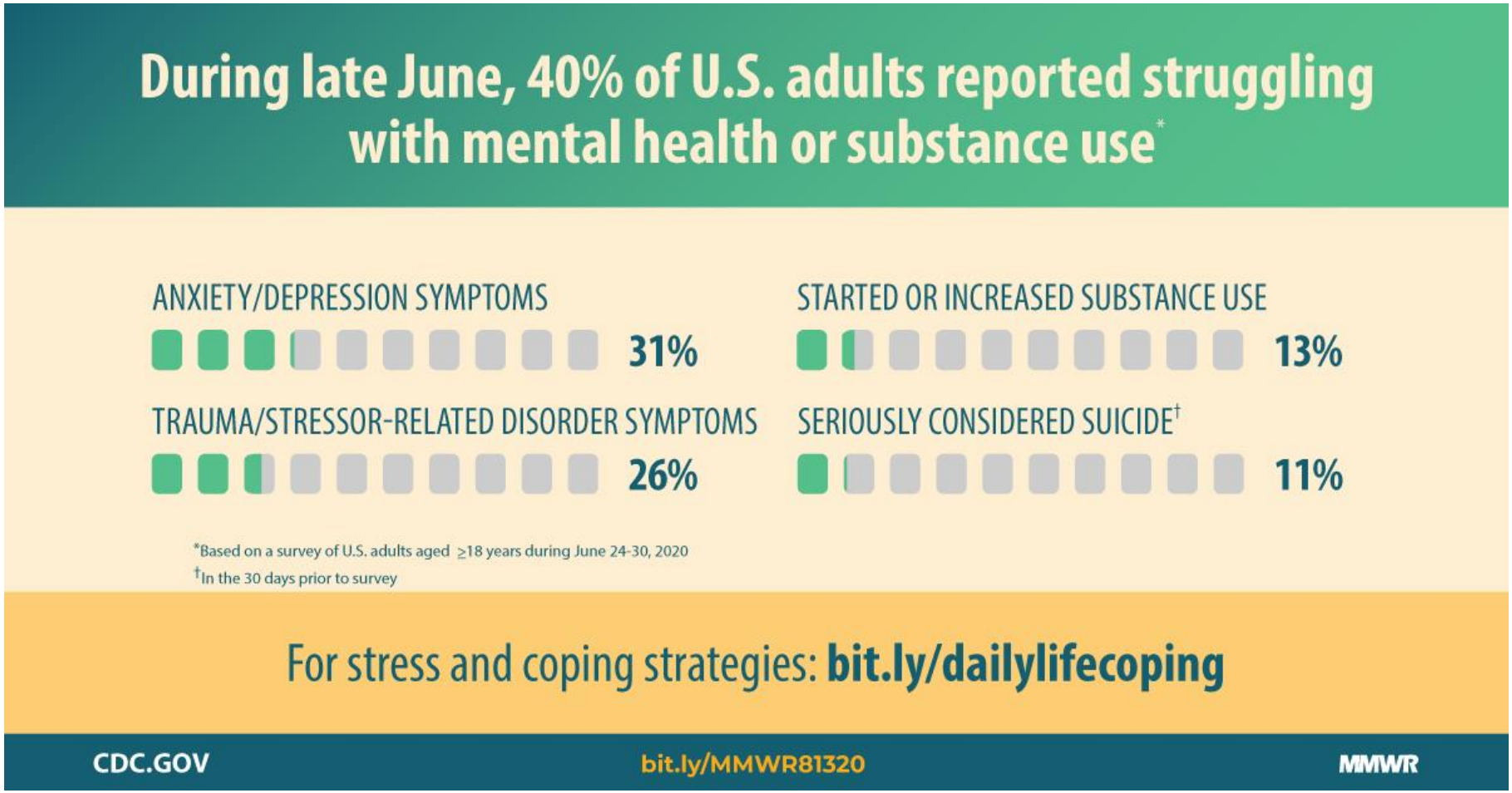
The incidence of suicide

- According to the CDC, in 2018, suicide was the tenth leading cause of death overall in the United States, claiming the lives of over 48,000 people.
- Suicide was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 54.
- There were more than two and a half times as many suicides (48,344) in the United States as there were homicides (18,830).

The incidence of suicide

- Veterans
- According to estimates from the CDC, Veterans account for approximately 22% of the deaths from suicide in the United States. This means that 18-22 Veterans die from suicide each day.
- About 67 percent of all Veteran deaths by suicide are the result of firearm injuries.
- Rates of suicide are highest among younger Veterans (ages 18–29).

The incidence of suicide (June, 2020)



Legal/liability issues

- **The fact that a client/patient died by suicide does not automatically imply that the therapist was negligent.**
- **For a determination of "negligence," there would have be some evidence that the client/patient demonstrated suicidal tendencies, and the therapist failed to competently assess the risks involved and take reasonable precautions.**

- James C. Olverholser, Ph.D, "Treatment of Suicidal Patients: A risk-benefit analysis," Behavioral Science and the Law, Vol. 13, 81-92, (1995).

Legal/liability issues

- There would have to have been a therapist-patient relationship in existence (for a legal duty to exist). And,
- There would have to be a contention that the therapist breached their duty of care to the client/patient, by falling below the standard of care that would be applicable to the treatment of that client/patient. And,
- The breach (failure to meet standards of care) resulted in harm to the client/patient (suicide) And,
- The client's suicide was foreseeable to the therapist.

Standard of care

- In a malpractice lawsuit against a health care professional, the primary issue is whether or not the professional practiced within the applicable standard(s) 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?
- An "expert" witness is used to help establish what the standard of care should be in a given circumstance.

Standard of care

- A therapist would breach the duty of care to the patient if he or she failed to meet the applicable standard of care.
- The standard of care that is applicable in a given situation depends on the actual facts and circumstances present in the case. It is based on the reasonable degree of skill, knowledge and care that is ordinarily exercised by other members of his or her professional community, when practicing under similar circumstances.

Standard of care

- **The standard of care is established by experts who, after a review of clinical records and available testimony, offer their opinion as to whether the care that was provided was *reasonable and prudent*, in light of what would customarily be employed in similar circumstances by professionals of similar training, experience, and skill.**
- Alan L. Berman, American Association of Suicidality, "Risk Management with Suicidal Patients," Journal of Clinical Psych: In Session, Feb., 2006.

standard of care

- In a malpractice action involving suicidality, experts will evaluate whether a suicide was foreseeable on the basis of information that was available to the clinician.
- In a given case, the failure to assess risk factors for suicide may constitute a breach of the standard of care.
- The assessment of suicide risk means that the clinician is evaluating their client's/patient's suicidal thoughts, plans, intent, and actions, as well as known risk factors and protective factors.
- Alan L. Berman, American Association of Suicidality, "Risk Management with Suicidal Patients," Journal of Clinical Psych: In Session, Feb., 2006.

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

[A/An] [*insert type of medical practitioner*] is negligent if [he/she] fails 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.]

Working with suicidal clients
Scope of competency

- Scope of competency
- Every professional is required to practice within the scope of his or her competency. 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.

Scope of competency

- **§1845. Unprofessional Conduct.**
- (a) **Performing or holding himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience.**
- (b) **Permitting a trainee or associate under his or her supervision or control to perform or permitting the trainee or associate to hold himself or herself out as competent to perform professional services beyond the trainee's or associate's level of education, training and/or experience.**

Foreseeability of harm

- A fundamental issue in a lawsuit against a therapist for negligence where the client died by suicide is whether or not the therapist was aware of facts from which he or she could have reasonably concluded that the client was likely to harm themself in the absence of preventive measures.
- If the therapist is aware of reasonably foreseeable harm to his or her client, then the therapist would be expected to take reasonable preventive measures. What is "reasonable," depends on the particular circumstances, and the needs of the particular client.
- A therapist cannot be expected to implement reasonable preventive measures in a case where the potential suicide of his or her client was not reasonably foreseeable to that therapist.

Foreseeability of harm

- What makes something "foreseeable" to the therapist? More specifically, 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. But, 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.

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 suicide in the absence of preventive measures**

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.
- That means: What would ordinarily be expected of a therapists who was working with the particular client/patient, under the circumstances? Would it be reasonable to expect that therapist to ask that client about suicide?

Identifying risk factors for suicide

- A therapist is not expected to predict what his or her client will do in the future, or to control the actions of his or her client.
- The therapist is expected to make reasonable efforts to evaluate the client, to determine the client's risk of suicide.
- No single list of questions is suited for every person. Every therapist will employ his or her own style or approach to gathering information about a client and arriving at a diagnosis and treatment plan.

Identifying risk factors for suicide

- **Mental health professionals are not expected to predict suicide, but are expected to identify the presence of risk. This means competently assessing the relative degree of risk of suicide, and implementing a treatment plan that is intended to reduce the risk.**
- **A clinician who either fails to reasonably assess a patient's risk of suicide or fails to implement a plan based on the presence of suicidal risk may be exposed to liability if the patient is ultimately harmed. In other words, if it could be argued: Had the mental health professional provided adequate assessment and treatment, the suicide may not have occurred.**

"Legal Issues of Professional Negligence in Suicide Cases," Wendy L. Packman, J.D., Ph.D., Tracy O'Connor Pennuto, J.D., M.A., Bruce Bongar, Ph.D., and Jennifer Orthwein, M.A. Behav. Sci. Law 22: 697–713 (2004) Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/bsl.613

Identifying risk factors for suicide

- **Assessment of risk is not analogous to prediction, considering that mental health professionals are not able to "predict" suicidal behaviors reliably.**

"Legal Issues of Professional Negligence in Suicide Cases," Wendy L. Packman, J.D., Ph.D., Tracy O'Connor Pennuto, J.D., M.A., Bruce Bongar, Ph.D., and Jennifer Orthwein, M.A. Behav. Sci. Law 22: 697–713 (2004) Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/bsl.61

Empirically informed risk-assessment

- In one literature review regarding suicide risk-assessment, the authors identified several key factors worthy of consideration by clinicians engaged in the treatment of patients with suicidal ideation, including: previous suicidal behavior; current suicidal symptoms, plans, methods and means for suicide; suicidal desire and intent; a sense of thwarted belongingness or perceived burdensomeness; engaging in non-suicidal self-injury; hopelessness; psychopathology, impulsivity; agitation, marked irritability; social withdrawal; severe weight loss; severe affective states and sleep disturbances.

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

- **In conducting an assessment of 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. The person's intent for suicide may increase if they are exposed to stress, or decrease as treatment progresses, and appropriate preventive measures are implemented.**

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

Empirically informed risk-assessment

- **No single risk factor or warning sign is pathognomonic (distinctively characteristic) for suicide.**
- **An evaluation of a person's risk for suicide should be as comprehensive as possible: A single suicide risk factor, or even combination of risk factors, does not have the statistical significance on which to base an overall risk assessment.**

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

Empirically informed risk-assessment

- Prior suicide-related behaviors are one indicator of current risk. Evidence suggests that both adults and adolescents with a history of multiple attempts are at greater risk compared with those with a history of one attempt or those who have never attempted suicide. A suicide attempt continues to influence risk for decades.

- Risk for death by suicide is elevated immediately after a suicide attempt and an elevated risk for suicide exists 6 months to 2 years after a suicide attempt. More recent attempts indicate relatively greater suicide risk.

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

- Current Suicidal Symptoms Approximately half of individuals who die by suicide do so on their first attempt. Two indicators of high suicide risk are suicidal thoughts and desire and defined plans and preparation for suicide.

- 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.

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.

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

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

- 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.

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

- Thwarted belongingness and perceived burdensomeness

"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.

- Clinicians should be concerned if a person lacks meaningful social connections, believes that they are burden to others, and expresses hopelessness about such conditions improving.

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

- Non-suicidal self-injury Recent 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 higher risk factors for suicide, vs. chronic high stress.

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

- 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, generally speaking, 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).

Empirically informed risk-assessment

- Impulsivity Suicidal risk is increased where the client has problems with impulsivity, but 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.

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

- 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.

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

- 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

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).

Reasonable preventive measures

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

- Undertaking reasonable preventive measures requires the therapist to be aware of factors which a client may experience as supportive, or "protective," meaning that they help to reduce the risk of suicide.

- What may be "reasonable," depends on the facts and circumstances. 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 he or she considers to be reasonable and appropriate for their client, at that point in time.

Preventive measures may include

- Facilitating the client's hospitalization (if appropriate)
- Consulting with the client's psychiatrist
- Arranging for the client to be evaluated by a psychiatrist
- Asking the client to agree to a safety plan
- Attempting to increase the degree of social support available to the client
- Involving a friend or family member in the client's treatment (with consent)
- Increasing the intensity of the treatment, such as increasing the number of sessions, or the amount of overall contact with the client

Preventive measures, cont'd

- **Obtaining a client's prior treatment record may constitute an example of a reasonable preventive measure. For example, depending on the circumstances, it could be argued that the prior treatment record may have helped the therapist to become aware of important diagnostic information, such as the client's history of homicidal or suicidal ideation. If the therapist's knowledge of such information would have made the possibility of harm to self or others foreseeable, the therapist might have been able to institute reasonable protective actions.**
- Jablonski v. United States, (1983) 712, F.2d 391

Elements of effective treatment

- Some research suggests that the effective treatment of mental health conditions (particularly major depression) reduces the risk of suicide and may decrease suicide rates. This includes both pharmaceutical treatments for mental illness and other forms of treatment, such as cognitive behavioral therapy, dialectical behavior therapy and family therapy, which have been shown to be effective in both reducing the symptoms of mental illness and the risk of suicidality.

Elements of effective treatment

- **Research has shown that <u>targeting and treating suicidal ideation and behaviors, independent of diagnosis, may have benefit in lowering suicidal risk</u>.**

- **When a client/patient is at risk of suicide, it is recommended that intervention and treatment be provided that is intended to directly and specifically target the potential suicidality. (In other words, the treatment of a person's depression may be insufficient, in itself, in lowering their risk of suicide.)**

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

The use of "no-suicide contracts"

- The use of no-suicide contracts 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 his or her client, wherein the client agrees not to harm him or herself, and to seek help from the therapist or other identified person, when he or she experiences suicidal urges.
- In spite of their prevalent use, there is little empirical evidence that no-suicide contracts are effective in preventing suicide, in the absence of other treatment efforts.

The use of "no-suicide contracts"

- **Various criticisms have been levied against the use of no-suicide contracts, including:**
- **There us no empirical support for their effectiveness in the clinical environment**
- **The use of a no-suicide contract may create an illusion of safety;**
- **The refusal of a client to agree to a no-suicide contract does not necessarily mean that he or she is at imminent risk of suicide.**

Rudd, David, M, Mandrusiak, Michael, Joiner, Thomas E. Jr., "The Case Against No-Suicide Contracts: The Commitment to Treatment Statement as a Practice Alternative," Journal of Clinical Psychology, Vol. 62(2), 243–251 (2006) Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20227

The use of "no-suicide contracts"

- The willingness of a client to agree to a no-suicide contract does not necessarily mean that the risk of suicide has been reduced.
- Psychiatric symptoms, such as severe depression or psychosis, may impede a client's mental capacity to enter into such an agreement.
- The client may be willing to sign such an agreement simply to placate the therapist.
- The client who feels amendable to entering such into the agreement at one moment in time may feel differently after leaving the therapist's office.

Rudd, David, M, Mandrusiak, Michael, Joiner, Thomas E. Jr., "The Case Against No-Suicide Contracts: The Commitment to Treatment Statement as a Practice Alternative," Journal of Clinical Psychology, Vol. 62(2), 243–251 (2006) Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20227

The use of "no-suicide contracts"

- **The use of the no-suicide contract does not insulate a provider from malpractice liability should the client commit suicide.**
- **For protection against liability, an ongoing assessment of suicide risk is necessary. A no-suicide contract is an event, whereas assessment of a client is a process.**

- Lee, Jeanne, B, Bartlett, Mary L., Suicide Prevention: Critical Elements for Managing Suicidal Clients and Counselor Liability Without the use of a No-Suicide Contract," Death Studies, 29: 847–865, 2005, Copyright # Taylor & Francis Inc. ISSN: 0748-1187 print/1091-7683 online DOI: 10.1080/07481180500236776

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 that information into a treatment protocol.
- Article is available on PubMed and via EBSCO on CAMFT website

The "Zero Suicide Model"

- 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.

The "Zero Suicide Model"

- 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.

The "Zero Suicide" Model

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

The "Zero Suicide" Model

- 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.
- Clinicians are often reluctant to ask such questions directly. In a 2014 survey of clinicians across New York State, 20% reported discomfort in asking about suicide, and 12% would not bring up the topic of suicide even if the patient's record or actions indicated risk .

The "Zero Suicide" Model

- Step 1: Inquire explicitly about suicidal ideation and behavior, past and present
- Every client does not need to be asked about the presence or absence of suicidal ideation. The need for such inquiry is premised on clinical presentation, such as the presence of one or more risk factors which suggest that there is a need for further evaluation of suicide risk.
- There is no single ideal list of questions which are appropriate in all circumstances, or with all clients. But there is a lot written on this subject. For example, in "Assessing and Treating Suicidal Behaviors, A Quick Reference Guide," by the American Psychiatric Association, clinicians are urged to specifically inquire about the person's suicidal thoughts, plans and behaviors, with recommended areas of inquiry by the therapist.

The "Zero Suicide" Model

- **Step 1: Inquire about suicidal Ideation and behavior,(cont'):**
- **Elicit 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.**

"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

- 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) and estimate the likelihood that such a plan will be formed or acted on in the near future.
- 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.
- Determine motivation for suicide, seriousness and extent of the patient's aim to die, associated behaviors or planning for suicide, and lethality of the method.

The "Zero Suicide" Model

- Step 2: Identify risk factors for suicide

The "Zero Suicide" Model

- 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 feel tomorrow.
- Clinicians should explicitly inquire about suicidal thoughts, urges, or behaviors at each contact, and revisit and update plans for staying safe.

The "Zero Suicide" Model

- 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.

The "Zero Suicide" Model

- 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.)

The "Zero Suicide" Model

- Step 5: Initiate and practice the use of coping strategies, cont'd:
- Such as: Help the client to develop a list of activities that can serve as distractions or help the client to self-calm,
  - Playing video games, taking a walk or a bike ride, etc.
  - Calling a friend
  - Engaging in artwork such as drawing or painting
  - Watching a movie or listening to music

The "Zero Suicide" Model

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

The "Zero Suicide" Model

- 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.

The "Zero Suicide" Model

- Step 7: Increase Availability to the Client, (cont'd)
- The Zero Suicide model recommends increased 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.

The "Zero Suicide" Model

- 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.

The "Zero Suicide" Model

- 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, contact or check-in regularly with the client to provide support, or reach out to the therapist when necessary.

The "Zero Suicide" Model

- Step 10: Collaborate with other professionals
- 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.

The "Zero Suicide Model"

- 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.

Youth Suicide

- The Incidence of Suicide among Youth
- Demographic Data/Risk Factors
- Relevant Protective Factors

- “

The incidence of suicide among youth

- From 2009 through 2018, the annual number of suicides of youth ages 12 to 19 in California increased from 163 to 188 (15 percent)

- "Youth Suicide Prevention," A Report By Auditor of the State of California,, September 2020.

The incidence of suicide among youth

- Suicidal ideation
- **The prevalence of suicidal ideation in adolescence is approximately 15–25%, ranging from thoughts of death passive ideation to specific suicidal ideation with intent or plan. The latter is much less frequent, with incidence rates of 6.0% and 2.3% in adolescent girls and boys, respectively**
- Suicide attempts
- **Estimates of suicide attempts among adolescents range from 1.3–3.8% in males and 1.5–0.1% in females, with higher rates of *attempts* in females than males in the older adolescent age range (But rates of completed suicide are higher in males among older adolescents.)**
- "Adolescent suicide and suicidal behavior, "Jeffrey A. Bridge, Tina R. Goldstein, and David A. Brent, Journal of Child Psychology and Psychiatry 47:3/4 (2006), pp 372–394

The incidence of suicide among youth

- Age -completed suicide
- Suicide rates consistently increase from childhood to adolescence, perhaps because of the greater prevalence of psychopathology in adolescents, and other factors.

	5-14 yrs.			15-24 yrs.		
	M	F	All	M	F	All
United States (2000)	**1.2**	**0.3**	**0.7**	**17.0**	**3.0**	**10.2**

- "Adolescent suicide and suicidal behavior," Jeffrey A. Bridge, Tina R. Goldstein, and David A. Brent, Journal of Child Psychology and Psychiatry 47:3/4 (2006), pp 372–394

Youth Suicide-demographic data/risk factors

- **Youth suicide is a growing health crisis in California.**
- **The annual number of suicides of youth ages 12 to 19 increased by 15 percent statewide from 2009 to 2018. In addition, instances of youth committing acts of self-harm—behavior that is self-directed and deliberately results in injury—increased by 50 percent during the same period.**

Sept., 2020 Report by California State Auditor on Youth Suicide Prevention

Youth Suicide: demographic data/risk factors

- **According to the CDC, in 2017, suicide was the second leading cause of death nationwide among individuals aged 10 to 24. A 2019 United Health Foundation report found that the teen suicide rate increased by 25 % nationwide from 2016 to 2019 and that California was one of seven states with the most significant increases in teen suicide rates during that same period.**

Sept., 2020 Report by California State Auditor on Youth Suicide Prevention

Youth Suicide: demographic data/risk factors

- **Youth are more vulnerable to suicide if they have certain characteristics and experiences, including mental health conditions, previous family suicide attempts, and exposure to prolonged stress, such as from harassment and bullying.**
- **The presence of psychiatric disorders, most notably major depressive disorder, is strongly associated with adolescent suicidal behavior. Depression is usually the strongest correlate of both suicidal ideation and attempts compared to other variables.**
- Risk Factors for Suicidal Behavior Among a National Sample of Adolescents: Implications for Prevention. Angela E. Waldrop, Rochelle F. Hanson, Heidi S. Resnick, and Dean G. Kilpatrick, *Journal of Traumatic Stress*, Vol. 20, No. 5, October 2007, pp. 869–879 (2007)

Youth Suicide: demographic data/risk factors

- **One study found that adolescent attempters who reported longer suicide planning (1 hr. or more) leading up to their most recent SA were at greater risk for a future attempt, compared with adolescents whose attempts were more impulsive**.

- Miranda, Ortin, Scott, and Shaffer,"Characteristics of suicidal ideation that predict the transition to future suicide attempts in adolescents," Journal of Child Psychology and Psychiatry (2014)

Youth Suicide: demographic data/risk factors

- **Studies have demonstrated that adolescents who engage in Non-suicidal self-injury ("NSSI") (self-harm that is deliberately inflicted on oneself by a person without a desire to die) are more likely to make suicide attempts than those who do not engage in NSSI.**
- **The association of NSSI with future suicide risk means that adolescents who engage in NSSI should be appropriately assessed for suicide risk.**

- Wilkinson, Paul, "Non-suicidal self-injury," European Child and Adolescent Psychiatry (2013) 22 (Suppl 1):S75–S79

Youth Suicide: demographic data/risk factors

- **Based on the CDC's high school youth risk behavior survey results, the % of high school students nationwide who seriously considered suicide increased from 14.5 % in 2007 to 17.2 % in 2017, while the % of attempted suicides increased from 6.9 percent to 7.4 %**

Sept., 2020 Report by California State Auditor on Youth Suicide Prevention

Youth suicide: Demographic data/risk factors

- **California counties with metropolitan areas have the highest total number of youth suicides, but data from the California Department of Public Health shows that many of the State's northern rural counties have higher suicide and self-harm rates.**
- **The higher rate of youth suicide rates in rural counties is likely affected by the availability of mental health professionals, which is generally lower in rural counties. Studies have generally found a positive association between increased access to care and lower suicide rates. However, in many rural communities, economic factors and sparse population density have led to shortages of mental health professionals, according to a report by the Rural Youth Suicide Prevention Workgroup.**
- "Youth Suicide Prevention," A Report By Auditor of the State of California,, September 2020.

Youth suicide: relevant protective factors

- Protective factors which may decrease the risk of youth suicide include, but are not limited to, the availability of mental health treatment resources, such as behavioral health care staff at a school, peer counseling services, and educational programs that increase awareness of help for family problems, relationship problems, depression, problem with bullying, etc.
- A supportive school or work environment are examples of protective factors. They are anything that reduces the likelihood of suicide attempts.

Youth Suicide: relevant protective factors

- **Multiple studies have identified positive associations between providing student suicide education and reducing suicide rates. For example, a 2015 study of Connecticut high school students found that a program intended to increase the students' abilities to identify warning signs of suicide and depression and to understand the importance of seeking help resulted in significantly fewer self-reported suicide attempts over the following three months.**

- **In 2016 the Legislature passed a law requiring LEAs that serve students in grades 7 to 12 to adopt suicide prevention policies. However, the six Local Education Agencies studied (LEA's) that were reviewed had not adopted policies that fully address the statutory requirements.**

Sept., 2020 Report by California State Auditor on Youth Suicide Prevention

Relevant exceptions to confidentiality: permitted disclosures

- 56.10 (c)(1) California Civil Code (Permitted disclosure to other health care providers)
- 56.10 (19) California Civil Code (Permitted disclosure to prevent or lessen a serious and imminent threat)

Permitted disclosure to other health care providers

- 56.10., Civil Code
- (c)(1) A provider of health care or a health care service plan may disclose medical information as follows (1) The information may be disclosed 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.

Permitted disclosure to prevent or lessen a serious and imminent threat

- **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."

Relevant case (disclosure permitted, not required)

- **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 committed 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.**

Bellah v. Greenson, (cont'd)

- 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. But, **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.**

CAMFT Code of Ethics- relevant sections

- 2.1 DISCLOSURES OF CONFIDENTIAL INFORMATION
- 3.4 EMERGENCIES/CONTACT BETWEEN SESSIONS
- 3.6 LIMITS OF CONFIDENTIALITY
- 5.3 CLIENT/PATIENT RECORDS

CAMFT Code of Ethics- relevant sections

- **2.1 <u>DISCLOSURES OF CONFIDENTIAL INFORMATION</u>:** Marriage and family therapists do not disclose client/patient confidences, (including the names or identities of their clients/patients), to anyone **except as mandated by law**, **as permitted by law**, when the marriage and family therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy (in which case client/patient confidences may only be disclosed in the course of that action), **or if there is an authorization previously obtained in writing.** Such information may only then be revealed in accordance with the terms of the authorization.

CAMFT Code of Ethics- relevant sections

- 3.4 <u>EMERGENCIES/CONTACT BETWEEN SESSIONS</u>: Marriage and family therapists inform clients/patients of the extent of their availability for emergency care between sessions.

CAMFT Code of Ethics- relevant sections

- 3.6 LIMITS OF CONFIDENTIALITY: Marriage and family therapists are encouraged to inform clients/patients of significant exceptions to confidentiality such as child abuse reporting, elder and dependent adult abuse reporting, and clients/patients dangerous to themselves or others

Standards of documentation

- 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.

Standards of documentation

- The importance of 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, that a reasonable effort was made by the therapist to identify risk factors, and that the therapist attempted to institute reasonable protective measures in keeping with his or her assessment.
- The record should reflect the degree to which a client was, or was not, cooperative with the therapist's efforts.
- The therapist's clinical documentation conveys whether or not the standard of care has been met in a given case.

Standards of documentation

- **Documentation should clearly reflect the therapist's thought processes and demonstrate their risk assessment, and the corresponding actions taken, or not taken, and reasons why. It is prudent to document not only actions taken, but actions considered.**
- **Risk–benefit analysis should be included, and reflect the clinician's decision-making process.**
- **For example, if the therapist considered involuntary hospitalization, but decided against such action, the documentation may include some explanation as to the possible damage to the therapeutic relationship as a risk to long-term safety of the person. to self-harm.**
- Stanley IH, Simpson S, Wortzel HS, Joiner TE. "Documenting suicide risk assessments and proportionate clinical actions to improve patient safety and mitigate legal risk," Behav. Sci. Law. 2019;37:304–312. https://doi.org/10.1002/bsl.2409

Documentation of treatment- Relevant Ethical Standard

- 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

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.

Relevant resource

- National Suicide Prevention hotline is 800 273-8255

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)

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

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.

Relevant resource

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

Vignettes

- Vignette one: Sam
- Vignette two: Angelica
- Vignette three: Martin
- Vignette four: Terry
- Vignette five: Jane

Vignette one: Sam

- Sam (68) is a new client of Ronald. During his first visit, Sam told Ronald that he wasn't sure why he was there, but he was planning on coming to "a few of these meetings" to satisfy his wife "who wanted him to do this for a long time." Sam told Ronald that his wife thought he was depressed, and "she might be right," but he was a private person who didn't usually talk about his problems. However, Sam said he was going to try to be open-minded to any suggestions that Ronald may have to offer.

- Sam said that he didn't have a lot of interest in most things, and since he retired, he spends a lot of time walking his dog, and watching television by himself. Sam didn't have a lot of social contact, but he looked forward to seeing his grandson, and about once a month he would meet for coffee with a few friends that he has known for many years. Unfortunately, ever since the Covid virus struck, Sam wasn't able to meet with his friends, and he found himself spending more time alone than ever. Even his wife was getting tired of being around him because of his irritable mood.

- During the evaluation, when Ronald asked Sam whether he had ever thought about suicide, Sam admitted that he had, "just about every day," but he would never do that because of how it would affect his wife. Sam also worried about what would happen to his dog if he was gone.

Questions-vignette one: Sam

- <u>Questions</u>
- What "risk-factors" should Ronald take into consideration in his assessment of Sam?
- What are the relevant "protective factors" in this case?
- What "reasonable preventive measures" should Ronald consider based on these facts?
- What additional questions should Ronald consider asking Sam to evaluate the risk of suicide?
- If you were offering consultation to Ronald, are there any treatment recommendations that you would consider offering to him about this case?

Vignette two: Angelica

- Angelica is a 17-year-old client of Carla. Angelica lives with her parents and her younger brother and attends high school on-line. Carla has been providing individual therapy to Angelica, along with occasional family therapy sessions, for the past few months. According to both Carla and Angelica, they have a positive therapeutic relationship, and the family sessions have been productive.

- Prior to working with Carla, Angelica participated in an adolescent intensive outpatient program ("IOP") for several weeks, where the primary treatment model was DBT. Prior to the IOP program, Angelica spend several days in a psychiatric inpatient unit for teens, following a suicide attempt.

- Angelica found the IOP program helpful and she continues to work at implementing the skills she learned, especially when she feels overwhelmed. Although Angelica (and her family) believe that she is doing much better now, she continues to have times where she "thinks about suicide," The family has removed objects such as knives and scissors from Angelica's access, because of her sporadic problems with thoughts of self-harm. These thoughts tend to occur at certain times, especially at night when she cannot sleep.

Questions-vignette two: Angelica

- What "risk-factors" should Carla take into consideration in her assessment of Angelica?
- What are the relevant "protective factors" in this case?
- What "reasonable preventive measures" should Carla consider based on these facts?
- What additional questions should Carla consider asking Angelica to evaluate the risk of suicide?
- If you were offering consultation to Carla are there any treatment recommendations that you would consider offering to her about this case?

Vignette three: Martin

- Martin is a 47-year-old client who has been receiving treatment from Susan for depression for the past six months. Martin has often complained to Susan that he is "not getting better," and that his mood "may be getting worse." In spite of his complaints however, Martin has never missed a single session.

- Given the lack of progress in Martin's treatment, and his ever-increasing pessimism, Susan has suggested to Martin that he have an evaluation by a psychiatrist for possible anti-depressant medication. Martin rejected that idea, and he told Susan that he can't stand going to doctors, with the possible exception of his family doctor, whom he has known for many years.

- A few months ago, when Susan asked Martin whether he ever thought about suicide, he replied, "a few times, but "could probably never do it." When Susan asked him the same question a few weeks later, Martin became visibly angry, and he told her, "If I ever feel like committing suicide, I will tell you." This was so unnerving to Susan that she has avoided asking him about suicide since that time.

Questions-vignette three: Martin

- What "risk-factors" should Susan take into consideration in her assessment of Martin?
- What are the relevant "protective factors" in this case?
- What "reasonable preventive measures" should Susan consider based on these facts?
- What additional questions should Susan consider asking Martin to evaluate the risk of suicide?
- If you were offering consultation to Susan, are there any treatment recommendations that you would consider offering to her about this case?

vignette four: Terry

- Terry (44) has been meeting with Mary for over six months and he recently told her his therapy sessions have been extremely helpful to him. Terry has struggled with bouts of serious depression all his life, but it became worse after he was involved in a serious motorcycle accident in his twenties. The accident, which took his friend's life, left Terry with a legacy of chronic pain. Now, over twenty years later, Terry finds himself in a terrible mood whenever the calendar approaches the anniversary of the accident, and to make matters worse, it took place just a few days away from his birthday. In a recent therapy session, Terry admitted to Mary that, if the pain ever became unbearable, he has saved up a large number of his pain meds for just such a need. Terry said he didn't intend to kill himself, but he felt better knowing that he could "just go to sleep" if he ever needed to.

Questions-vignette four: Terry

- What "risk-factors" should Mary take into consideration in her assessment of Terry?
- What are the relevant "protective factors" in this case?
- What "reasonable preventive measures" should Mary consider based on these facts?
- What additional questions should Mary consider asking Terry to evaluate the risk of suicide?
- If you were offering consultation to Mary, are there any treatment recommendations that you would consider offering to her in this case?

Vignette five: Jane

- Jane (18) has been meeting with Ann (a registered MFT associate) at the local community clinic for the past few months. Although Jane's mom made the initial appointment for her, Jane insists that she is attending voluntarily and she agrees that she has "tons of problems that she needs help with." Jane has a history of problems with impulsivity, depression, and possible alcohol abuse. Although she has been actively engaged in her therapy sessions, she has a habit of canceling at the last minute. When confronted about her attendance, Jane admitted that she has a problem remembering things sometimes, and she promised Ann that she would try to be on time. Jane did not complete high school, but she has a plan to work on her G.E.D. Although Jane denies any current suicidal ideation, she told Ann that she "took a bunch of Tylenol once," about a year ago, after breaking up with a boyfriend.

Questions-vignette five: Jane

- What "risk-factors" should Ann take into consideration in her assessment of Jane?
- What are the relevant "protective factors" in this case?
- What "reasonable preventive measures" should consider based on these facts?
- What additional questions should Ann consider asking Jane to evaluate the risk of suicide?
- If you were Ann's supervisor:
  - Are there any treatment recommendations that you would consider offering to her?
  - What questions would you want to ask Ann?

Thank you!

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

858-292-2638