University of California
School of Social Welfare
Field Preparation
Panel

DANGEROUSNESS
TO SELF AND OTHERS
in Social Work Practice

Presenter,
Stan Taubman, PhD, LCSW
# Contents

Social Work: A Multifaceted Profession ................................................. 3
- Licensed and Unlicensed Direct Practice
- Health Care Services and Social Services
- Psychotherapy and Non-Psychotherapy forms of Clinical Social Work

Informed Consent ................................................................................. 5

The Legal “Standard of Care” .............................................................. 6

Ethics ....................................................................................................... 8

Unprofessional Conduct per the LCSW License Law ......................... 9

Confidentiality and Privacy ................................................................. 13
- Ethics ............................................................................................... 13
- W&I Code (practice in public agencies) ............................................. 16
- COMIA (practice in private settings) ................................................. 18
- Psychotherapist-Patient Privilege ...................................................... 20

The “Tarasoff Duty” .......................................................... 27

Involuntary Holds: Welfare and Institutions Code Sec. 5150 ............. 30
  Grave Disability .................................................................................. 32

Summary Chart of Legal and Ethical Duties Regarding Confidentiality and Danger 33

Suicide Risk .......................................................................................... 34

Assault Risk ......................................................................................... 39
  Assessing Recidivism Risk ................................................................. 42

Summary of Key Issues: Practical Considerations .............................. 47
SOCIAL WORK
A MULTIFACETED PROFESSION

The Clinical Social Work Scope of Practice

CLINICAL SOCIAL WORK
From Section 4996.9 of the Business and Professions Code:

The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior is directed at helping people to achieve more adequate, satisfying and productive social adjustments. The application of social work principles and methods includes but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families and groups, providing information and referral services, providing or arranging for the provision of social services, explaining and interpreting the psychosocial aspects in the situation of individuals, families or groups, helping communities to organize, to provide or improve social and health services, and doing research related to social work.

Psychotherapy, within the meaning of this chapter, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups or communities in respect to behavior, emotions and thinking, in respect to their intrapersonal and intrapersonal processes.
ARE YOU PROVIDING PSYCHOTHERAPY?

1. Did you tell your client that the service you are providing is “psychotherapy” or “therapy”? Did you tell your client that the service you are providing is “not psychotherapy” or “not therapy”?

2. Do your agency’s publicity materials say that the agency provides “psychotherapy” or “therapy”?

3. Does your Job Description say that your role is to provide “psychotherapy” or “therapy”?

4. If your agency bills an insurance plan on a fee for service basis, are your services billed to the plan as “psychotherapy”? If your agency has a contract for grant funds, does the contract show that the funding source is paying for “psychotherapy” services?

IF YES...

5. Did you obtain your client’s informed consent to provide “psychotherapy”?
   • Did you inform your client of the nature, risks, potential benefits and other implications of being a psychotherapy client?
   • Did you inform your client about relevant HIPAA protections, psychotherapist-patient privilege, and Tarasoff requirements?
   • Did you provide your client with a HIPAA compliant Notice of Privacy Practices, if your are a “covered entity”?

6. Are you documenting the standard elements of a health care clinical record? These include...
   (1) Chief complaint(s) / (presenting problem(s))
   (2) Pertinent history and initial assessment findings
   (3) Findings from consultations and referrals to other health care providers
   (4) Validated Diagnosis
   (5) Treatment plan
   (6) Recommendations and interventions provided to the client, and client response
   (7) Progress in response to treatment
   (8) Assessment findings emerging during treatment
   (9) Prognosis
   (10) Discharge summary in closed cases

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
INFORMED CONSENT
TO RECEIVE SOCIAL WORK SERVICES

Based on the value of client self-determination, the NASW Code of Ethics calls on social workers to obtain informed consent prior to providing services to clients. The Code of Ethics specifies what the client needs to be informed about in order for their consent to be considered “informed consent.”

1.03 Informed Consent
(a) Use clear and understandable language to inform clients of...
   • the purpose of services
   • risks related to the services
   • limits to the services because of third party payor requirements
   • relevant costs
   • reasonable alternatives
   • clients' right to refuse or withdraw consent
   • and the time frame covered by the consent.
   Provide clients with the opportunity to ask questions.
(b) If clients are not literate or have difficulty understanding the primary language used in the practice setting, provide a detailed verbal explanation or arrange for qualified translation services if possible.
© When clients lack the capacity to provide informed consent, seek permission from an appropriate third party, informing the client consistent with their level of understanding. Take steps to enhance the client's ability to give informed consent.
(d) When clients receive involuntary services, provide information about the nature and extent of services and about the extent of the client's right to refuse services.
(e) If services are provided via electronic media (e.g. computer, telephone), inform clients of the associated limitations and risks.
(f) Obtain informed consent before audio taping, videotaping, or permitting observation of services to clients by third parties.

Elsewhere in the Code of Ethics, Standard 1.07 addresses Privacy and Confidentiality and states: “(e) Discuss the nature and limitations of confidentiality with clients and interested others.”

The “limitations of confidentiality” are among the “risks related to the services” as addressed in the Code section regarding Informed Consent.
THE LEGAL “STANDARD OF CARE”

The "standard of care" refers to a professional's legal duty to act "in a prudent and reasonable manner." Negligence has been defined by federal Courts as “Failure to use care which a reasonable and prudent person would use under similar circumstances.” Essentially this means that therapists and other professionals must adhere to a "community standard of practice" and follow the professional standards that are followed by others of the same profession with comparable qualifications in similar localities.

Standard of Care for Health Care Professionals

Section 501, California Civil Jury Instructions

A [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.]

The "standard of care" is often referenced in malpractice suits when a client feels that he or she has suffered harm due to a therapist's negligent failure to adhere to the "standard of care." For example...

- a client suffers injuries in an automobile accident which occurred when driving while intoxicated and sues the therapist for failing to conduct an adequate substance abuse assessment....or, sues the therapist for knowing that the client had a substance abuse issue but failed to treat it properly
- a client severely injures his back as the result of jumping off of a high place in a failed suicide attempt, and sues the therapist for failing to conduct an adequate suicide risk assessment...or, sues the therapist for knowing that the client was suicidal but failed to manage the suicide risk properly

©2012  Stan Taubman, PhD, LCSW and the Berkeley Training Associates
The "standard of care" is an abstract concept. In a court of law the attorney for the plaintiff will generally bring in **expert witnesses** of the same profession and from the same locality as the defendant, establish that they are "prudent and reasonable" people, and examine them to establish what they would have done if they were the therapist in the case at issue.

The defendant therapist will likely testify as to what actions were taken, and **the clinical record will weigh heavily in supporting or discounting the therapist's claims. In some cases only the clinical record, and not the therapist's testimony, will be the basis for determining the quality of care that has been provided.**
1. Social Workers' Ethical Responsibilities to Clients

1.01 Commitment to Clients

Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised.

1.02 Self-Determination

Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.

(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.
UNPROFESSIONAL CONDUCT
per the California LCSW License Law

Section 4992.3 of the Business and Professions Code (LCSW) sets forth conditions for the "Suspension, Revocation of License" related to "Unprofessional Conduct." These legal requirements are based on ethics, therefore, these issues are both ethical and legal issues. Notice that the law states that "Unprofessional conduct includes, but is not limited to:". This phrase means that violating any of the profession's ethical principles can be treated also as a legal matter.

B.& P. C. 4992.3

The board may deny a license or a registration, or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter is a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.
© Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022 or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license. The board shall deny an application for a registration or license or revoke the license or registration of any person who uses or offers to use drugs in the course of performing clinical social work. This provision does not apply to any person also licensed as a physician and surgeon under Chapter 5 (commencing with Section 2000) or the Osteopathic Act who lawfully prescribes drugs to a patient under his or her care.

(d) Incompetence in the performance of clinical social work.

(e) An act or omission that falls sufficiently below the standard of conduct of the profession as to constitute an act of gross negligence.

(f) Violating, attempting to violate, or conspiring to violate this chapter or any regulation adopted by the board.

(g) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity. For purposes of this subdivision, this misrepresentation includes, but is not limited to, misrepresentation of the person's qualifications as an adoption service provider pursuant to Section 8502 of the Family Code.

(h) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee, allowing any other person to use his or her license or registration.

(i) Aiding or abetting any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(j) Intentionally or recklessly causing physical or emotional harm to any client.

(k) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.
(l) **Engaging in sexual relations** with a client or with a former client within two years from the termination date of therapy with the client, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a clinical social worker.

(m) **Performing, or holding one's self out as being able to perform, or offering to perform** or permitting, any registered associate clinical social worker or intern under supervision to perform **any professional services beyond the scope of the license** authorized by this chapter.

(n) **Failure to maintain confidentiality, except as otherwise required or permitted by law,** of all information that has been received from a client in confidence during the course of treatment and all information about the client that is obtained from tests or other means.

(o) Prior to the commencement of treatment, **failing to disclose to the client or prospective client the fee to be charged** for the professional services, or the basis upon which that fee will be computed.

(p) **Paying, accepting, or soliciting any consideration, compensation, or remuneration,** whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (o).

(q) **Advertising in a manner that is false, fraudulent, misleading, or deceptive,** as defined in Section 651.

© Reproduction or description in public, or in any publication subject to general public distribution, of **any psychological test or other assessment device,** the value of which depends in whole or in part on the naivete of the subject, in ways that might invalidate the test or device. A licensee shall limit access to that test or device to persons with professional interest who are expected to safeguard its use.

(s) Any conduct in the supervision of any registered associate clinical social worker, intern, or trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.
(t) **Failure to keep records** consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(u) **Failure to comply with the child abuse reporting requirements** of Section 11166 of the Penal Code.

(v) **Failure to comply with the elder and dependent adult abuse reporting requirements** of Section 15630 of the Welfare and Institutions Code.

(w) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code. (Note: This section addresses **patient access to records**.)

(x) Failure to comply with Section 2290.5. (Note: This section addresses “**Telemedicine**”.)

(y) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section. (2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from **sexual misconduct** by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for **sexual conduct with a minor occurring prior to the effective date of this section**.

(z) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of the examination as described in Section 123.

* * *

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
CONFIDENTIALITY
EXCERPTS FROM THE NASW CODE OF ETHICS
(bolding added)

1.07 Privacy and Confidentiality

(a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.

(b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.

© Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

(d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

(e) Social workers should discuss with clients and other interested parties the nature of confidentiality and limitations of clients' right to confidentiality. Social workers should review with clients circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. This discussion should occur as soon as possible in the social worker-client relationship and as needed throughout the course of the relationship.

(f) When social workers provide counseling services to families, couples, or groups, social workers should seek agreement among the parties involved concerning each individual's right to confidentiality and obligation to preserve the confidentiality of information shared by
others. Social workers should inform participants in family, couples, or group counseling that social workers cannot guarantee that all participants will honor such agreements.

(g) Social workers should inform clients involved in family, couples, marital, or group counseling of the social worker's, employer's, and agency's policy concerning the social worker's disclosure of confidential information among the parties involved in the counseling.

(h) Social workers should not disclose confidential information to third-party payers unless clients have authorized such disclosure.

(i) Social workers should not discuss confidential information in any setting unless privacy can be ensured. Social workers should not discuss confidential information in public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants.

(j) Social workers should protect the confidentiality of clients during legal proceedings to the extent permitted by law. When a court of law or other legally authorized body orders social workers to disclose confidential or privileged information without a client's consent and such disclosure could cause harm to the client, social workers should request that the court withdraw the order or limit the order as narrowly as possible or maintain the records under seal, unavailable for public inspection.

(k) Social workers should protect the confidentiality of clients when responding to requests from members of the media.

(l) Social workers should protect the confidentiality of clients' written and electronic records and other sensitive information. Social workers should take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.

(m) Social workers should take precautions to ensure and maintain the confidentiality of information transmitted to other parties through the use of computers, electronic mail, facsimile machines, telephones and telephone answering machines, and other electronic or computer technology. Disclosure of identifying information should be avoided whenever possible.

(n) Social workers should transfer or dispose of clients' records in a manner that protects clients' confidentiality and is consistent with state statutes governing records and social work licensure.
(o) Social workers should take reasonable precautions to protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.

(p) Social workers should not disclose identifying information when discussing clients for teaching or training purposes unless the client has consented to disclosure of confidential information.

(q) Social workers should not disclose identifying information when discussing clients with consultants unless the client has consented to disclosure of confidential information or there is a compelling need for such disclosure.

® Social workers should protect the confidentiality of deceased clients consistent with the preceding standards.
CONFIDENTIALITY

WELFARE AND INSTITUTIONS CODE SEC. 5328
APPLIES TO COMMUNITY MENTAL HEALTH SERVICE SYSTEMS ET AL.

The California Welfare and Institutions Code provides the fundamental rule governing confidentiality in public agencies which are operated by, or which contract with county mental health services.

W & I Code Sec. 5328. All information and records obtained in the course of providing services under Division 4 (commencing with Section 4000), Division 4.1 (commencing with Section 4400), Division 4.5 (commencing with Section 4500), Division 5 (commencing with Section 5000), Division 6 (commencing with Section 6000), or Division 7 (commencing with Section 7100), to either voluntary or involuntary recipients of services shall be confidential.

Information and records obtained in the course of providing similar services to either voluntary or involuntary recipients prior to 1969 shall also be confidential. Information and records shall be disclosed only in any of the following cases:

(a) In communications between qualified professional persons in the provision of services or appropriate referrals, or in the course of conservatorship proceedings. The consent of the patient, or his or her guardian or conservator shall be obtained before information or records may be disclosed by a professional person employed by a facility to a professional person not employed by the facility who does not have the medical or psychological responsibility for the patient's care.

(b) When the patient, with the approval of the physician, licensed psychologist, social worker with a master's degree in social work, or licensed marriage and family therapist, who is in charge of the patient, designates persons to whom information or records may be released, except that nothing in this article shall be construed to compel a physician, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family. Nothing in this subdivision shall be construed to authorize a licensed marriage and family therapist to provide services or to be in charge of a patient's care beyond his or her lawful scope of practice.

© To the extent necessary for a recipient to make a claim, or for a claim to be made on behalf of a recipient for aid, insurance, or medical assistance to which he or she may be entitled.

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
(d) **If the recipient of services is a minor**, ward, or conservatee, and his or her parent, guardian, guardian ad litem, or conservator designates, in writing, persons to whom records or information may be disclosed, except that **nothing in this article shall be construed to compel** a physician, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, nurse, attorney, or other professional person to reveal information that has been given to him or her in confidence by members of a patient's family.

(r) When the patient, in the opinion of his or her **psychotherapist**, presents a **serious danger of violence to a reasonably foreseeable victim** or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons. **For purposes of this subdivision, "psychotherapist" means anyone so defined within Section 1010 of the Evidence Code.**

Section 5328.04.

(a) Notwithstanding Section 5328, information and records made confidential under that section **may be disclosed** to a county social worker, a probation officer, or any other person who is legally authorized to have custody or care of a minor, for the purpose of coordinating health care services and medical treatment, as defined in subdivision (b) of Section 56.103 of the Civil Code, mental health services, or services for developmental disabilities, for the minor.  © Information disclosed pursuant to this section shall not be admitted into evidence in any criminal or delinquency proceeding against the minor. Nothing in this subdivision shall prohibit identical evidence from being admissible in a criminal proceeding if that evidence is derived solely from lawful means other than this section and is permitted by law.

(d) **Nothing in this section shall be construed to compel** a physician and surgeon, licensed psychologist, social worker with a master's degree in social work, licensed marriage and family therapist, licensed professional clinical counselor, nurse, attorney, or other professional person to reveal information, including notes, that has been given to him or her in confidence by the minor or members of the minor's family.

(e) The disclosure of information pursuant to this section is not intended to limit disclosure of information **when that disclosure is otherwise required by law**.
CONFIDENTIALITY

CONFIDENTIALITY OF MEDICAL INFORMATION ACT (COMIA)

CIVIL CODE SECTIONS 56.10 - 56.245
APPLIES TO PRIVATELY OWNED HEALTH ORGANIZATIONS
AND PRIVATE PRACTICES

This section of California law addresses confidentiality of all health care services, with a special section regarding psychotherapy. This law applies to private practice as well as to privately operated clinics and hospitals.

Sec. 56.10.
(a) No provider of health care, health care service plan, or contractor shall disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as provided in subdivision (b) or ©.

YOU MUST DISCLOSE IF COMPELLED

(b) A provider of health care, a health care service plan, or a contractor shall disclose medical information if the disclosure is compelled by any of the following:

(1) By a court pursuant to an order of that court.
(2) By a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority.
(3) By a party to a proceeding before a court or administrative agency pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to Section 1987 of the Code of Civil Procedure, or any provision authorizing discovery in a proceeding before a court or administrative agency.
(6) By a search warrant lawfully issued to a governmental law enforcement agency.
(7) By the patient or the patient's representative pursuant to Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.
(9) When otherwise specifically required by law.

Note that many other disclosure obligations are also listed.

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
(14) The information may be disclosed when the disclosure is otherwise specifically authorized by law, including, but not limited to, the voluntary reporting, either directly or indirectly, to the federal Food and Drug Administration of adverse events related to drug products or medical device problems, or to disclosures made pursuant to subdivisions (b) and (c) of Section 11167 of the Penal Code by a person making a report pursuant to Sections 11165.9 and 11166 of the Penal Code, provided that those disclosures concern a report made by that person.

(15) Basic information, including the patient's name, city of residence, age, sex, and general condition, may be disclosed to a state-recognized or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries.

(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.

(d) Except to the extent expressly authorized by the patient or enrollee or subscriber or as provided by subdivisions (b) and (c), no provider of health care, health care service plan contractor, or corporation and its subsidiaries and affiliates shall intentionally share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient.

* * *

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
PSYCHOTHERAPIST-PATIENT PRIVILEGE

CALIFORNIA EVIDENCE CODE
BEGINNING AT SECTION 1010...

California recognizes that confidentiality is an indispensable aspect of effective psychotherapy. As a result, the State has enacted various statutes designed to protect confidential disclosures between patients and psychotherapists from being revealed in judicial proceedings.

Note that, unlike other confidentiality rules the psychotherapist-patient privilege applies only to the attempted disclosure of confidential communications in judicial or administrative proceedings. This protection is relevant to...

- trials
- depositions
- subpoenas for the examination of records.

California's psychotherapist-patient privilege statute does not provide such protection to the clients of clinical social workers when...

- the social worker is not the patient's psychotherapist (i.e. the social worker is providing the client with services other than psychotherapy)
- the communication to the therapist was not made in confidence
- the privilege has been waived by the holder of the privilege
- one of many exceptions to the privilege applies

* * *

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
CALIFORNIA EVIDENCE CODE SECTIONS
PERTAINING TO PSYCHOTHERAPIST-PATIENT PRIVILEGE

Ev.C. 1010 PSYCHOTHERAPIST

As used in this article, "psychotherapist" means:

(a) A person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry.

(b) A person licensed as a psychologist.

© A person licensed as a clinical social worker when he or she is engaged in applied psychotherapy of a nonmedical nature.

(d) A person who is serving as a school psychologist and holds a credential authorizing such service issued by the State.

(e) A person licensed as a marriage, family and child counselor.

(f) A person registered as a psychological assistant who is under the supervision of a licensed psychologist or board certified psychiatrist as required by Section 2913 of the Business and Professions Code, or a person registered as a marriage, family and child counselor intern who is under the supervision of a licensed marriage, family and child counselor, a licensed clinical social worker, a licensed psychologist, or a licensed physician certified in psychiatry, as specified in Section 4980.44 of the Business and Professions Code.

(g) A person registered as an associate clinical social worker who is under the supervision of a licensed clinical social worker, a licensed psychologist or board certified psychiatrist....

(h) A person exempt from the Psychology Licensing Law pursuant to subdivision (d) of Section 2909 of the Business and Professions Code who is under the supervision of a licensed psychologist or board certified psychiatrist.

(i) A psychological intern as defined in Section 2911 of the Business and Professions Code who is under the supervision of a licensed psychologist or board certified psychiatrist.

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
As used in this article, "confidential communication between patient and psychotherapist" means information, including information obtained by an examination of the patient, transmitted between a patient and his psychotherapist in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation, or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the psychotherapist is consulted, and includes a diagnosis made and the advice given by the psychotherapist in the course of that relationship. (1970, Ch. 1379)

As used in this article, "holder of the privilege" means:
(a) The patient when he has no guardian or conservator.
(b) A guardian or conservator of the patient when the patient has a guardian or conservator.
(c) The personal representative of the patient if the patient is dead.
Ev.C. 1014  PSYCHOTHERAPIST-PATIENT PRIVILEGE

Subject to Section 912 and except as otherwise provided in this article, the patient, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist if the privilege is claimed by:
(a) The holder of the privilege;
(b) A person who is authorized to claim the privilege by the holder of the privilege; or...
(c) The person who was the psychotherapist at the time of the confidential information, but such person may not claim the privilege if there is no holder of the privilege in existence or if he or she is otherwise instructed by a person authorized to permit disclosure.

Ev.C. 1015  WHEN PSYCHOTHERAPIST IS REQUIRED TO CLAIM PRIVILEGE

The psychotherapist who received or made a communication subject to the privilege under this article shall claim the privilege whenever he is present when the communication is sought to be disclosed and is authorized to claim the privilege under subdivision © of Section 1014. (1965, Ch. 299)
EXCEPTIONS TO THE PRIVILEGE

Evidence Code Sections 1016-1027 set forth several exceptions to the privilege. There is no privilege under this article under the following conditions:

Section 1024. There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.

OTHER EXCEPTIONS...

• when the patient is a litigant and an issue concerning the mental or emotional condition of the patient arises if such issue has been tendered by the patient, his/her beneficiary, or someone claiming through or under the patient

This exception applies when the patient brings a legal proceeding in which he or she alleges that they have suffered psychological injury due to another person's conduct. (It also applies when a criminal defendant raises the question of their own sanity...see below.) In such cases the courts can access otherwise privileged communication in order to fairly adjudicate the patient's claim.

• if the psychotherapist is appointed by order of the court (this exception does not apply if the court order was requested by the patient's defense lawyer in a criminal proceeding)

This exception applies when a psychotherapist is appointed by order of the court in a proceeding which is held to determine the mental competence of a patient. These might include guardianship, conservatorship or commitment proceedings.
- if the services of the psychotherapist were sought to enable or aid anyone to commit a **crime** or tort or to escape detection or apprehension after committing a crime or tort

  This exception applies in cases where the services of a psychotherapist were sought or obtained to enable a patient to commit or plan to commit a crime or tort or to escape detection or apprehension after the commission of a crime or tort. For example, the patient might seek treatment as part of an insurance fraud scheme.

- if the communication **involves an issue of breach of duty by the psychotherapist or the patient** arising out of their relationship

  This exception means that, if your patient sues you for malpractice (breach of duty) you may reveal otherwise privileged information from your sessions with the client in order to defend yourself.

- if the patient is deceased and the communication is **relevant to settling a will or property interest**

  There is no privilege if a former communication from a now deceased patient is needed to clarify their intent in executing a "dispositive instrument" such as a will.

- if it involves a **proceeding to determine the sanity of a criminal defendant**

  This exception applies when a defendant raises the question of his or her own sanity in a criminal trial. In such cases the courts can access otherwise privileged communication in order to fairly adjudicate the patient's claim.

- if the psychotherapist has reasonable cause to believe that the patient is in such condition as to be **dangerous to self or others or to property of another and that disclosure is necessary to prevent the threatened danger**

  This exception to the privilege applies to Tarasoff warnings and communications related to establishing a 5150 hold when needed to prevent a danger.

- in a proceeding brought by or on behalf of the patient **to establish his competence**
• if it concerns information that either the psychotherapist or the patient is **required by law to report to a public employee**, if such report is open to public inspection

  This exception to the privilege applies to mandated reports which become a matter of public record.

• if the **patient is a child under the age of 16 and the psychotherapist has reasonable cause to believe that the patient has been the victim of a crime** and that disclosure of the communication is in the best interest of the child

  This exception applies not only to mandated child abuse reports, but also to any reports that might be made regarding crimes against a child.

* * *

©2012  Stan Taubman, PhD, LCSW and the Berkeley Training Associates
THE TARASOFF DUTY

“The Duty to Warn”

In 1974 the California Supreme Court established the principle that requires physicians and psychotherapists to warn intended victims of dangerous patients. This is known as the Tarasoff Decision. It is based on a legal principle known as "duty to warn." Key provisions of the duty to warn were elaborated in a 1976 court decision containing the following statement.

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 of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.

When exercising this duty to warn, a psychotherapist may become vulnerable to suits based on breach of confidentiality or privileged communication. As a result, the law gives psychotherapists immunity from monetary liability.

Section 43.92, California Civil Code

PSYCHOTHERAPISTS; DUTY TO WARN OF THREATENED VIOLENT BEHAVIOR OF PATIENT; IMMUNITY FROM MONETARY LIABILITY

(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 warn of and protect from a patient's threatened violent behavior except where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.
The Tarasoff Decision, which formed the original basis for this law, is a judicial decision based on an interpretation of laws and precedents. It has since been clarified in a series of judicial decisions. Therefore, the duty to warn is an evolving principle. In a California Supreme Court review of Tarasoff vs. Regents of the University of California "the Tarasoff Decision" ruled that the therapist should have warned the potential victim or the police. Subsequent decisions, however, clearly required notification of both the potential victim and the police. Also note that the Tarasoff Decision involved a threat to commit murder.

It is not clear how much violence short of murder requires a duty to warn. Other related judicial decisions include the following.

☛ Thompson v. County of Alameda (1980)
The court decided that the duty to warn did not apply in a case where only a generalized threat was made regarding a class of people. In this case the generalized threat involved young children.

Mr. Cribbs, who had a history of involuntary treatment at the VA, bought a gun at Sears. One month later, he left his outpatient VA program against medical advice. Thirty days later he fired his shotgun in an Omaha club, killing Mr. Lipari and wounding Mrs. Lipari. Mrs. Lipari sued Sears, and Sears sued the VA. Mrs. Lipari also sued the VA. A District Court ruled that the VA had a duty to detain dangerous people if they are a threat to the public (based on Tarasoff).

☛ Jablonski by Pahls v. United States, United States Court of Appeals, Ninth Circuit (1983)
Ms. Kimball and Mr. Jablonski were dating. She was afraid of his past threats, attempts to kill her mother (Ms. Pahls), and her as well. She took him to the Loma Linda VA when he had threatened her mother, on 7/10/78. The doctor recommended that she should leave him, but felt that he was not dangerous, in view of the fact that Mr. Jablonski was not currently threatening her. He was released, and then killed Ms. Kimball 7/16/78. Ms. Kimball’s daughter (with help of Kimball’s mother Ms. Pahls) sued the VA, alleging that the psychiatrist had a duty to protect Ms. Kimball. The Court ruled that Ms. Kimball was a foreseeable victim of Jablonski’s violence, and necessary steps were not taken in protecting her.
Naidu v. Laird, Supreme Court of Delaware (1988)

Mr. Putney was released from the Delaware State Hospital after being treated for symptoms of a paranoid psychotic episode. It was his seventh admission. He left a voluntary admission in March 1977. **Five months later**, while in a psychotic state, he drove a car over Mr. Laird and killed him. Ms. Laird sued. The Supreme Court of Delaware held that Mr. Laird was a foreseeable victim to Mr. Putney’s dangerousness, and that the duty to warn Mr. Laird was not properly discharged.

In re Kevin F. (1989)

A therapist disclosed a patient's past arson behavior when it was feared that the patient might pose an arson risk within an institution. The therapist was found to have committed no violation, suggesting that a therapist's discretion to disclose is broader than the therapist's requirement to disclose.


This case established the principle that a Tarasoff duty applies when the therapist becomes aware of a danger through hearsay information from a patient's family member if that information "leads the therapist to believe or predict that the patient poses a serious risk of grave bodily injury to another..." This appears to be a reasonable clarification since the original Tarasoff ruling did not specify that the therapist must become aware of the danger only through information provided by the patient. It would not be surprising if future cases establish that any form of reliable hearsay information, even though not presented by a patient's family, should be acted on.
IN Voluntary Detention of Dangerous or Gravely Disabled Persons

W.I.C. 5150  DANGEROUS OR GRAVELY DISABLED PERSON; TAKING INTO CUSTODY; APPLICATION; BASIS OF PROBABLE CAUSE; LIABILITY

When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation.

Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of attending staff, or professional person, and stating that the officer, member of attending staff, or professional person has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false. (Amend by Stats. 1980, Ch. 968)

W.&I.C. 5151  DETENTION FOR EVALUATION - 72 HOUR PATIENT

If the facility for a 72-hour treatment and evaluation admits the person, it may detain him or her for evaluation and treatment for a period not to exceed 72 hours. Saturdays, Sundays, and holidays may be excluded from the 72-hour period if the Department of Mental Health certifies for each facility that evaluation and treatment services cannot reasonably be made available on
those days. The certification by the department is subject to renewal every two years. The department shall adopt regulations defining criteria for determining whether a facility can reasonably be expected to make evaluation and treatment services available on Saturdays, Sundays and holidays.

If in the judgment of the professional person in charge of the facility providing evaluation and treatment, or his designee, the person can be properly served without being detained, he shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis. (Amend Stats. 1978, Ch. 1294)

W.&I.C. 5152 EVALUATION, TREATMENT, CARE, RELEASE - 72-HOUR PATIENT

Each person admitted to a facility for 72-hour treatment and evaluation under the provisions of this article shall receive an evaluation as soon after he is admitted as possible and shall receive such treatment and care as his condition requires for the full period that he is held. Such person shall be released before 72 hours have elapsed if, in the opinion of the professional person in charge of the facility, or his designee, the person no longer requires evaluation or treatment.

Persons who have been detained for evaluation and treatment shall be released, referred for further care and treatment on a voluntary basis, certified for intensive treatment, or a conservator or temporary conservator shall be appointed pursuant to this part as required. (Amend Stats. 1970, Ch. 1627)

* * *

©2012  Stan Taubman, PhD, LCSW and the Berkeley Training Associates
WELFARE AND INSTITUTIONS CODE SECTION 5008.
GRAVE DISABILITY

W&I Code Section 5008(h)

(1) For purposes of Article 1 (commencing with Section 5150), Article 2 (commencing with Section 5200), and Article 4 (commencing with Section 5250) of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means either of the following:

(A) A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.

(B) A condition in which a person, has been found mentally incompetent under Section 1370 of the Penal Code and all of the following facts exist:

(I) The indictment or information pending against the defendant at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person.

(ii) The indictment or information has not been dismissed.

(iii) As a result of mental disorder, the person is unable to understand the nature and purpose of the proceedings taken against him or her and to assist counsel in the conduct of his or her defense in a rational manner.

(2) For purposes of Article 3 (commencing with Section 5225) and Article 4 (commencing with Section 5250), of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means a condition in which a person, as a result of impairment by chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing, or shelter.

(3) The term "gravely disabled" does not include mentally retarded persons by reason of being mentally retarded alone.
### LEGAL AND ETHICAL RESPONSIBILITIES RELATED to DANGER

<table>
<thead>
<tr>
<th>Law/Ethical Standard</th>
<th>Non-Psychotherapy MSW’s</th>
<th>Non-Psychotherapy LCSW’s</th>
<th>LCSW Psychotherapists</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Past Dangers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Abuse Report</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Abuse Report</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Predicting Future Dangers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal “Standard of Care”</td>
<td>???</td>
<td>Yes, if in a health care setting</td>
<td>Yes</td>
</tr>
<tr>
<td>Tarasoff Duty</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>5150</td>
<td>Only if Authorized</td>
<td>Only if Authorized</td>
<td>Only if Authorized</td>
</tr>
<tr>
<td><strong>Confidentiality and Professional Conduct</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unprofessional Conduct Law</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Unprofessional Conduct Ethics</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>W&amp;I Code Confidentiality</td>
<td>If in a public mental health service</td>
<td>If in a public mental health service</td>
<td>Yes, if in a public MH service</td>
</tr>
<tr>
<td>H&amp;S Code Confidentiality</td>
<td>If in a privately owned health care service</td>
<td>If in a privately owned health care service</td>
<td>Yes, if in a private practice; special rules apply</td>
</tr>
<tr>
<td>Privileged Comm.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Breach Confidentiality if Danger?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Law</td>
<td>Permitted</td>
<td>Permitted</td>
<td>Required</td>
</tr>
<tr>
<td>W&amp;I Code 5328</td>
<td>No</td>
<td>No</td>
<td>Permitted</td>
</tr>
<tr>
<td>Ev. Code Sec. 1024</td>
<td>NA</td>
<td>NA</td>
<td>Permitted</td>
</tr>
<tr>
<td>Code of Ethics</td>
<td>Permitted</td>
<td>Permitted</td>
<td>Permitted</td>
</tr>
</tbody>
</table>
SUICIDE RISK

SUICIDE RISK ASSESSMENT

Suicidal Ideation: If present, does the client....

a. Intend to act on it?

b. Want to live or want to die?

c. Have reasons for living?

d. Feel negative/frightened about suicidal thoughts or welcome them?

e. Have only abstract/general thoughts or have specific thoughts regarding the suicide plan, circumstances surrounding death, the funeral, etc.?

f. Attempt to keep the suicidal thoughts under control?

g. Think about it fleetingly or as a persistent preoccupation?

h. Perceive available sources of help/support or believe there's nowhere to turn?

i. Seek help or avoid interference with suicidal plans?

j. Prepare for death? Feel prepared for death?

k. Plan out or write a suicide note?

l. Think about a specific method of suicide?

m. Have available the means by which to carry out the method?

Demographics: Highest risk is associated with...

• males
• over age 40 (also high risk in adolescence)
• divorced/separated/widowed
• living alone
• unemployed/retired.
Motivation:
- Wishes to influence someone's behavior (lowest risk).
- Wishes to escape an intolerable situation, intrapsychic or external, by death (highest risk).
- Ask the person what he/she believes will result from his/her death and what effect it is expected to have on significant others.
- People motivated to die will generally increase the seriousness of their suicidal behavior. People motivated to influence another's behavior generally increase the seriousness of their suicidal behavior if there has been no response to their past behavior.

Mental Disorders and Symptoms:
- **Diagnoses:** Risk is associated with severe depression, thought disorder (grossly disorganized thought), hallucinations or delusions regarding death or suicide, borderline personality disorder, or substance abuse/dependence.
- **Impulse Control:** Has there been a history of suicide attempts? Arrests for assaultive behavior? Reckless driving? Other signs of low threshold for anxiety and frustration or poor impulse control?

Resources/Significant Others:
- Are significant others available and accessible?
- Does their presence exacerbate or reduce client’s distress?
- Does the client believe their suicidality draws attention or esteem from others?
- Do significant others place reinforce the client’s negative intentions?

Past Suicide Behavior:
- If so, how lethal was it?
- What is the client's concept of the prior attempt's lethality?
- How does the client feel about the outcome of prior attempts?
- What were the conditions preceding and during the prior attempt? Stresses? Provocations? Frustrations? Are there similar circumstances now?

* * *

MANAGING SUICIDE RISK
1. Decide whether or not you can handle it.
   - Do you have either the experience and knowledge base or is adequate supervision or consultation available to you?
   - Are you linked to supportive resources such as medical consultation, suicide prevention center staff, or personally supportive colleagues?
   - Can you be available to the client at almost all times?
   - Are you already treating one or more suicidal clients?
   - Are you working through your own deep depression, suicidal thinking, loss of a loved one or other suicidal client?
   - Are you sufficiently aware of your own anxiety about suicide and the responsibilities associated with treating a suicidal client?

2. Openly discuss suicide.
   - The client needs to develop a cognitive grasp of his or her situation and suicidality.
   - The client needs to know that you are not too fearful about the subject to be helpful.

3. Make agreements (sometimes referred to as “contracts”).
   - If outpatient therapy is considered the client should be able to agree to not attempt suicide while in therapy and for a specified time period. The client should further agree to use therapy toward the purpose of making this no suicide commitment a permanent one.
   - Agree on exactly what the client should do when feeling suicidal.
   - The client should agree to call you prior to carrying out his or her suicide plan.
   - The client should surrender weapons, poisons, and/or "pill connections." It may be wise to enlist the aid of a family member in this effort.
   - Later contracts can be developed regarding the client's frequency of social contacts, physical activity level, diet, grooming, and other issues as relevant.
4. **Formulate a clear and specific initial treatment plan.**
   - Agree on a frequency and duration of contact.
   - How long will sessions be?
   - What will you talk about?
   - What will be your objectives?
   - Who else will be involved in the treatment process?
   - Be sure the client and family members understand the plan.

5. **Be accessible.**
   - Let the client know when and where to reach you by phone. Be sure your agency staff know where to reach you and know to provide professional back up if you cannot be reached.
   - Be prepared to increase the frequency of visits or to set ad hoc appointments.
   - Let the client know whom to call when you are not accessible.

6. **Discuss responsibility.**
   - Let the client know you don't want him to kill himself. However, if the client attempts to manipulate you through suicide threats let him know that you will not accept responsibility for his death.

7. **Acknowledge suicide as one alternative.**
   - ...and note that death is the most unknown and final alternative.
   - Encourage the client to postpone thinking about suicide until other options have been identified and considered.
8. Stimulate hope.
   • Give reassurance but only if you can also let the client know you understand the full depth of his or her suffering.
   • Discuss the natural tendency of depression toward remission.
   • Discuss prior problems or times of despair in the client's life and focus on how the situation resolved.

9. Discuss relevant perceptions and feelings.
   • Note the client's ambivalence. Reinforce the desire to live. In helping the client express and examine such feelings as shame, anger, hostility also recognize the client's positive self-evaluations and affection and concern for others.
   • Focus on that which has given life meaning, including significant others, work, hobbies, pets, music and other places or interests that have given the client pleasure.

10. Involve significant others.
    • They can support the client and help monitor risk indicators.
    • The family dynamics may be supporting depression and self-destructiveness on the part of the client and may be accessible to change.
    • Family members may need information and support.

11. Develop social skills.
    • Suicide is generally associated with frustrated desires for gratification from others. Assertion skills are a more effective way of resolving this problem.

    • Encourage the client to go to work and attend structured activities.
    • Develop "homework" assignments to build structure and activity into the client's day.
    • Structure in therapy is also helpful in motivating and engaging the client. This is especially important for the suicidal client who is often confused and concrete.

* * *
ASSAULT RISK

Assaultive behavior is extremely difficult to predict. The best indicator is whether or not the person has engaged in prior assaultive behavior (see section on Recidivism Risk). Beyond that, the following should be addressed in making a comprehensive assessment and forming professional judgment of a client's potential for assault.

Clinical Features: While individuals with any diagnosis, or no diagnosis at all, might engage in assaultive behavior, look for the following symptoms and diagnoses.

- **Symptoms:** signs of anxiety, especially with a sense of desperation, thought disorder, command hallucinations, persecutory delusions, ideas of reference, paranoid personality traits, and poor impulse control or poor frustration tolerance.

- **Diagnoses:** signs of intermittent explosive disorder, antisocial or borderline personality disorder, manic episode, an organic personality syndrome, or substance abuse.

- **Impulse Control:** Has there been a history of suicide attempts? Arrests for assaultive behavior? Reckless driving? Other signs of low threshold for anxiety and frustration or poor impulse control?

- **Object Relations:** Does the person perceive others as strong or superior, while viewing themselves as weak, inferior, or powerless? Has this perception led to ambivalent, shallow or stormy relationships?

Developmental History:

- What was the level of violence in the person's early family?

- Which family members were violent? With whom? How was it acted out? How frequently?


- Were any of the following present during the person's developmental years?
  - enuresis
  - fire setting
  - cruelty to animals
Significant Others:
- Are significant others available and accessible?
- Do they approve or disapprove of the client's assaultive behavior or ideation?
- Does the client believe their assaultiveness draws attention or esteem from others?
- Do significant others place blame on the intended victim, thereby lending support to the client's assaultive intentions?

Past Assaultive Behavior:
- How destructive was it?
- What is the client's concept of the prior behavior's consequences?
- What are the client's feelings about the outcome of prior assaults?
- What were the conditions preceding and during the assault? Stresses? Provocations? Frustrations? Are there similar circumstances now?
- Who was the target of prior assaults? What was the victim's relationship to the perpetrator?
- Was it goal directed or cathartic?

Assaultive Ideation: If present, does the client....
- intend to act on it?
- feel negative/frightened about assaultive thoughts or welcome them?
- attempt to keep the assaultive thoughts under control?
- think about a specific method of assault?
- have available the means by which to carry out the method?
- fear losing control? Does the person experience somatic distress that might be a way of experiencing this fear of losing control?
- exercise control over aggressive impulses? How? What techniques are used? How effective are they? How does the person feel about his experience in exercising control over aggressive impulses?
Other Issues:

- Ask the client what he/she believes will result from his/her assaultive behavior and what effect it is expected to have on significant others.
- If the person has been under stress, has he been frustrated in his efforts to seek assistance?
- Does he view the intended victim as instrumental in frustrating his efforts to obtain assistance?
- Is the intended victim perceived by the client as provocative?
- Has the intended victim been victimized by others?
- What is the nature of the client's relationship with the intended victim? Is it characterized by sarcasm? Condescension? Is it intense and unstable? Dependent or codependent?
FRAMEWORK FOR ASSESSING RECIDIVISM RISK IN ASSAULTIVE OR EXPLOITIVE INDIVIDUALS

The following criteria have been associated with prognosis and recidivism risk in individuals who have engaged in a variety of assaultive or exploitive behaviors and other impulse control problems. Recidivism and risk are extremely difficult to predict. This framework should be used in the context of a comprehensive biopsychosocial assessment.

ASSESSING RECIDIVISM RISK

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>LOWER RISK</th>
<th>HIGHER RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>THE OFFENSE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUMBER AND PATTERN OF OFFENSES</td>
<td>Single occurrence</td>
<td>Multiple occurrences of an escalating nature</td>
</tr>
<tr>
<td>PERSISTENCE</td>
<td>Situational or opportunistic</td>
<td>Compulsive, driven quality</td>
</tr>
<tr>
<td>ACCEPTANCE OF RESPONSIBILITY</td>
<td>Accepts full responsibility for offense and its consequences</td>
<td>Denies offense or places blame on someone else</td>
</tr>
<tr>
<td>GUILT</td>
<td>Sense of guilt with desire for restitution</td>
<td>Without guilt or overwhelmed by guilt</td>
</tr>
<tr>
<td>DRUG ABUSE</td>
<td>Played no role in offense</td>
<td>Involved in offense</td>
</tr>
<tr>
<td>DISCUSSION OF OFFENSE</td>
<td>Willing to explore it non-defensively</td>
<td>Defensive, very anxious, and/or hostile</td>
</tr>
<tr>
<td>INVESTIGATION</td>
<td>Full participation, cooperative</td>
<td>Uncooperative, hostile</td>
</tr>
</tbody>
</table>

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
<table>
<thead>
<tr>
<th>ISSUE</th>
<th>LOWER RISK</th>
<th>HIGHER RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSONALITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OVERALL PATTERN</td>
<td>Normal</td>
<td>Severe personality disorder, psychosis, organic disorder</td>
</tr>
<tr>
<td>SELF-CONCEPT</td>
<td>Well differentiated</td>
<td>Global, undifferentiated</td>
</tr>
<tr>
<td>SEX ROLE SELF-IMAGE</td>
<td>Androgynous</td>
<td>Stereotypic and rigid</td>
</tr>
<tr>
<td>SELF-ESTEEM</td>
<td>Generally high</td>
<td>Generally weak, shameful</td>
</tr>
<tr>
<td>IMPULSE CONTROL</td>
<td>Generally normal</td>
<td>Weak or rigid</td>
</tr>
<tr>
<td>FRUSTRATION TOLERANCE</td>
<td>Has goals; adapts to failure</td>
<td>No goals; failure leads to depression, hostility or deep sense of shame</td>
</tr>
<tr>
<td>RELATIONS WITH AUTHORITY</td>
<td>Cooperative and cautious</td>
<td>Defiant and/or blind compliance</td>
</tr>
<tr>
<td>OBSESSIONS</td>
<td>None</td>
<td>Sexual and/or aggressive obsessions</td>
</tr>
<tr>
<td>SOCIAL RELATIONS</td>
<td>Uses assertion and negotiation; flexible and mutual</td>
<td>Rigid and narcissistic</td>
</tr>
<tr>
<td>ISSUE</td>
<td>LOWER RISK</td>
<td>HIGHER RISK</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>SEXUALITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOW CONTACT WAS MADE</td>
<td>Negotiation and consent</td>
<td>Use or threat of force; deception; intimidation</td>
</tr>
<tr>
<td>PURPOSE</td>
<td>Sensual pleasure; expression of love</td>
<td>Eroticized aggression; dominance; retaliation</td>
</tr>
<tr>
<td>HOW PERSISTENT</td>
<td>Situational; part of broader social interactions</td>
<td>Preoccupation; compulsive or driven quality</td>
</tr>
<tr>
<td>PROGRESSION</td>
<td>Stable or positive growth</td>
<td>Emergent ritualism; sadism</td>
</tr>
<tr>
<td>EXTRA-FAMILIAL</td>
<td>No sexual assaults outside the family</td>
<td>Sexual assault outside the family</td>
</tr>
<tr>
<td>ISSUE</td>
<td>LOWER RISK</td>
<td>HIGHER RISK</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>FAMILIAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOMESTIC VIOLENCE</td>
<td>None</td>
<td>Spousal or child physical abuse</td>
</tr>
<tr>
<td>SPOUSE</td>
<td>Holds offender fully responsible; doesn't tolerate abuse or humiliation;</td>
<td>Protects offender; blames victim; tolerates abuse/humiliation; dependent or</td>
</tr>
<tr>
<td></td>
<td>autonomous; assertive</td>
<td>counter-dependent; submissive or domineering</td>
</tr>
<tr>
<td>VICTIM</td>
<td>Holds offender fully responsible; sees the offense as harmful; able to</td>
<td>Blames self; protects offender; sees offense as harmless; sexualizes</td>
</tr>
<tr>
<td></td>
<td>relate non-sexually; autonomous; assertive</td>
<td>relationships; submissive, dependent, or counterdependent</td>
</tr>
<tr>
<td>STRESS</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>STRESS MANAGEMENT</td>
<td>Effective stress reduction</td>
<td>Family dysfunctional under stress</td>
</tr>
</tbody>
</table>

©2012 Stan Taubman, PhD, LCSW and the Berkeley Training Associates
### Relation to Victim

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>LOWER RISK</th>
<th>HIGHER RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESPONSE TO VICTIM'S DISTRESS</td>
<td>Discontinued the assaultive behavior when victim showed distress</td>
<td>Victim's resistance heightened arousal and assaultive behavior</td>
</tr>
<tr>
<td>UNDERSTANDING OF EXPLOITATION</td>
<td>Understands exploitive nature of the offense</td>
<td>Does not understand and resists discussion of the issue</td>
</tr>
<tr>
<td>UNDERSTANDING OF IMPACT</td>
<td>Understands negative impact on victim</td>
<td>Does not understand &amp; resists discussion of the issue</td>
</tr>
<tr>
<td>EMPATHY WITH VICTIM</td>
<td>Can empathize</td>
<td>Little or no capacity for empathy</td>
</tr>
<tr>
<td>VICTIMIZATION</td>
<td>Not victimized</td>
<td>Victimized; repeated victimization</td>
</tr>
</tbody>
</table>

### History

<table>
<thead>
<tr>
<th>VICTIMIZATION</th>
<th>Lower Risk</th>
<th>Higher Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not victimized</td>
<td>Victimized; repeated victimization</td>
</tr>
</tbody>
</table>
SUMMARY OF KEY ISSUES

In carrying out a “duty to warn” or other protective actions consider these principles.

1. Be clear regarding your role, and the options and responsibilities that apply to you in that role. Obtain a client’s informed consent as early as possible in your work together, based on this understanding.

2. Don’t wait for a mandated report to be necessary. Consider using any available means for reducing the violence threat, whether or not a duty to warn is involved.

3. Collaborate!

4. Carefully assess the severity of the threat and the likelihood of its being carried out.

5. If a client explicitly threatens to murder an identifiable victim there is a clear duty to warn the victim and the police. If the client implies a threat of violence other than murder, weigh the violence risk versus (a) the risk of violating confidentiality and (b) the risk of unduly frightening the warned individual.

6. Release no more information than is needed for the intended victim’s protection.

7. Document your risk assessment and actions taken. Document your judgment about the balance between risks and benefits involved....the whole story, both positive and negative findings.

8. Obtain the client's cooperation or consent in warning the third party if at all possible.