Berkeley Social Welfare

Assessing Client Dangerousness To Self and Others: *Stratified Risk Management Approaches*

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Social Workers' Responsibilities

- Both legal and ethical
- Include respecting both client self-determination and confidentiality
- There are circumstances under which it is a social workers responsibility to supersede these.

Continuum of Actions

- The degree to which confidentiality is breached, self-determination is usurped, and outside intervention is imposed should be directly related to the seriousness of threat and the vulnerability of the client

Relevant Ethical Standards from NASW Code of Ethics

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 so be advised.

1.01 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' rights 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.

1.07 Privacy and Confidentiality

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.

Relevant California Laws Related to Lawful Breach of Confidentiality

Welfare and Institutions Code 5150

When any person, as a result of mental disorder, is a danger to others, or to himself, or herself, or gravely disabled[1]*, a peace officer, member of the attending staff . . . of an evaluation facility designated by the county, designated members of a mobile crisis team . . . 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.*

Civil Code 43.92

. . . If the patient has communicated . . .a serious threat of physical violence against a reasonably identifiable victim or victims . . .a psychotherapist discharges his or her duty to protect by making reasonable efforts to communicate the threat to the intended victim or victims and to a law enforcement agency . . .

[1] "Grave disability" usually refers to the condition of a client who is so impaired by a mental disorder that they are unable to meet their basic needs for food, clothing, or shelter and/or who has been assessed by a medical professional to be "mentally incompetent" due to mental disorder.

Relevant Case Law for Breaching Confidentiality

Tara off v. Regents of UC (1974, 1976)

The Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a "duty to protect" the intended victim. The professional may discharge the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Ewing v. Goldstein (2004)

Upheld in appellate court, Ewing v. Goldstein is a landmark court case that extended California mental health professional's duty to protect identifiable victims of potentially violent to include acting upon communications from third parties, particularly family members and particularly if that information "leads the therapist to believe or predict that the patient poses a serious risk of grave bodily injury to another."

Suicide Facts in the U.S.

- Twice as many suicides as homicides
- The rate appears to be rising, increasing 12% between 1999 and 2009
- In 2009, suicide was the tenth leading cause of death overall and the third leading cause for people ages 15-24
- 33% of people who commit suicide had contact with mental health services a year before their death, 20% within the last month of their life. (Schmitz, Allen, Feldman et al, 2012)

Ecological Perspectives on Suicide

Key Variables Related to Risk and Protection

- Presence of certain co-occurring mental disorders
- Demographics/social identities
- Socioeconomic status (employment, income)
- Availability of and quality of social supports and relationships
- Cultural beliefs (religious and otherwise)
- Recency, severity and recurrence of aggravating stressors

Suicide Risk Factors (Evidence-Based)

- Suicidal ideation
- Recurrent, chronic major depressive episodes (with co-occurring disorders)
- Previous suicide attempts and hospitalization
- Knowing others who committed suicide
- Relational, social, or economic losses
- Age (15-24, age 50 and over)
- Physical illness and disability
- High isolation, stigma, and hopelessness
- Immediate access to methods of self-harm

Competent Clinical Care for Suicide

- Recognize and detect risk
- *Thoroughly interview* regarding current suicidal desire/ideation, plans, means, intent, and especially past attempts and protective factors
- Determine level of imminent risk
- Develop and document a collaborative intervention plan appropriate to the situation and level of risk

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Key Suicide Risk Assessment Questions

Suggested Clinician Style: ***Friendly*** (compassionate, warm, concerned, supportive, client-centered), ***Frank*** (direct, candid, unafraid to ask or talk about risks plainly), and ***Firm*** (asking in a confident tone and insisting that this discussion is essential, imperative, and necessary). These help establish therapeutic trust, clear expectations, and relational honesty.

1. Suicidal Ideation

(Normalize): When someone feels as upset as you do, they may have thoughts that life isn't worth living.

What thoughts have you had like this?

2. Suicidal Planning (Means)

If you decided to try to end your life, how would you do it?

Tell me about the plans you've made.

3. Access to Means

You mentioned that if you were to hurt yourself, you'd probably do it by (describe method). How easy would it be for you to do this?

4. Protective Factors

(Normalize): People often have very mixed feelings about harming themselves.

What are some reasons that would stop you or prevent you from trying to hurt yourself? What is it that most holds you back from actually doing this?

5. Past Experiences

What have been your past experiences of making attempts to hurt yourself? What other people do you know who have tried to or have ended their own life?

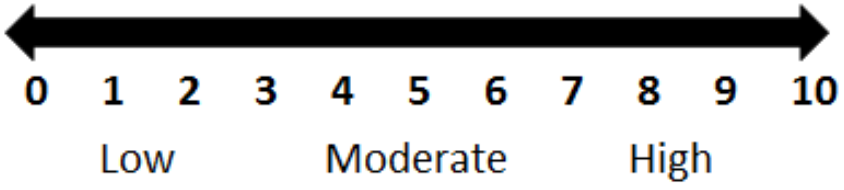
6. Future Expectations

What are some of the things happening in your life or likely to happen in your life right now that would either make you more or less likely to want to hurt yourself?

How do you think people who know you would react if you killed yourself? What would they say, think, or feel?

Continuum of Risk

- Given the severity and specificity of the ideation, given the presence of risk and protective factors, and given recent and/or anticipated stressors, what is the current level of imminent ("about to occur") risk?



Tarasoff Ruling (1976)

"When a therapist determines, or pursuant to the standards of his or her 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 on 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."

Competent Clinical Practice for Homicidality

- Recognize and detect risk
- *Thoroughly interview* regarding current homicidal desire/ideation, plans, means, intent, and especially past violence and protective factors
- Determine level of imminent risk
- Develop and document a collaborative intervention plan appropriate to the situation and level of risk

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Key Homicide Risk Assessment Questions

Suggested Clinician Style: ***Friendly*** (compassionate, warm, concerned, supportive, client-centered), ***Frank*** (direct, candid, unafraid to ask or talk about risks plainly), and ***Firm*** (asking in a confident tone and insisting that this discussion is essential, imperative, and necessary). These help establish therapeutic trust, clear expectations, and relational honesty.

7. Homicidal Ideation

(Normalize): When someone feels as upset as you do, they may have thoughts about hurting the person who has upset or hurt them.

What thoughts have you had like this?

8. Planning (Means)

If you decided to try to hurt _____, how would you do it?
Tell me about the plans you've made.

9. Access to Means

You mentioned that if you were to hurt _____, you'd probably do it by (describe method). How easy would it be for you to do this?

10. Protective Factors

(Normalize): People often have very mixed feelings about harming other people.

What are some reasons that would stop you or prevent you from trying to hurt _____? What is it that most holds you back from actually doing this?

11. Past Experiences

What have been your past experiences related to hurting people who have hurt you?

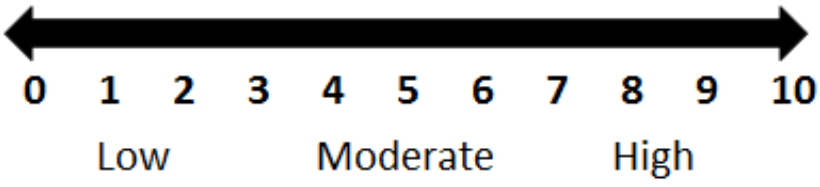
12. Future Expectations

What are some of the things happening in your life or likely to happen in your life right now that would either make you more or less likely to want to hurt_____?

How do you think people who know you would react if you actually did this? What would they say, think, or feel? What would be some of the consequences?

Continuum of Risk

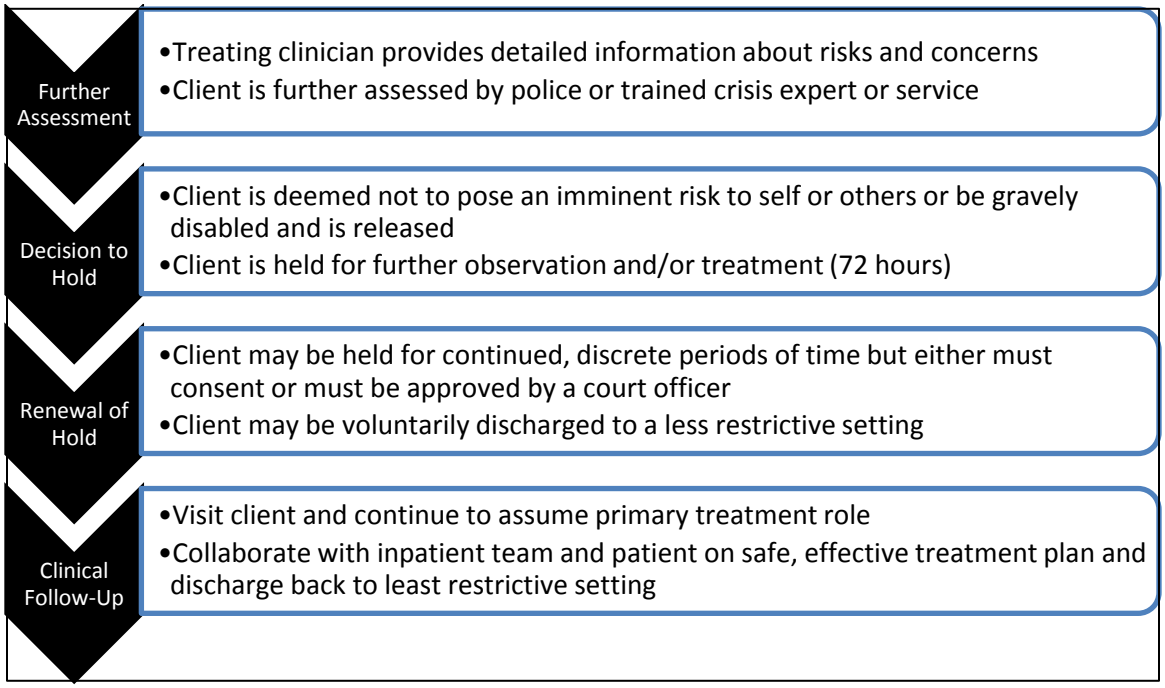
- Given the severity and specificity of the ideation, given the presence of risk and protective factors, and given recent and/or anticipated stressors, what is the current level of imminent ("about to occur") risk?



Stratified Clinical Responses to Risk

Risk Level	Intervention Options
Low	• Provide client with support and affirmation • Instill hope without invalidating despair • Help client to improve and expand coping related to immediate stressors and environment • Help client to avoid, minimize, or respond differently to immediate stressors • Help client to enlist family, friend, and community supports • Provide advocacy to remove stressors or access supports • Develop a basic safety plan • Discuss possible medication referral and other helpful self-management options • Reassess periodically • Document
Medium	In addition to the above, consider: • Consultation with or second opinion from experienced clinician • Involving the client's support system • Developing a more specific safety plan and/or contract; specifically, client should agree to call identified crisis resources prior to carrying out plan • The client should surrender access to lethal means • Encourage structure in the client's life including homework and scheduled activities
HIGH	In addition to the above, consider: • Arranging for further crisis assessment by mobile crisis time or psychiatry emergency center with or without patient's knowledge and consent • In the instance where client poses danger to identifiable others, make reasonable efforts to call, write, or reach them

What Usually Happens After 5150 is initiated?



Practical Guidance on Informing Intended Victim or Victims

- Immediately attempt to reach victim by phone, email, or message
- You may discuss the specific threat, plan, or intent, who has issued the threat, its immediate context, and the clinician's rationale for determining that its seriousness including previously known history of violence if it relates to this threat. You may only disclose information deemed "absolutely necessary."
- You may send police out to attempt notification if you cannot reach the intended victim by phone or other means
- You may send a certified, next day letter or hand-deliver a letter to the last known address.

VA Safety Plan: Brief Instructions[2]

Step 1: Recognizing Warning Signs

__ Ask "*How will you know when the safety plan should be used?"*

__ Ask, "*What do you experience when you start to think about suicide or feel extremely distressed?*"

__ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients' own words.

Step 2: Using Internal Coping Strategies

__ Ask *"What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?"*

__ Ask *"How likely do you think you would be able to do this step during a time of crisis?"*

__ If doubt about using coping strategies is expressed, ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"

__ Use a collaborative, problem solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3: Social Contacts Who May Distract from the Crisis

__ Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.

__ Ask *"Who or what social settings help you take your mind off your problems at least for a little while? "Who helps you feel better when you socialize with them?"*

__ Ask patients to list several people and social settings, in case the first option is unavailable.

__ Ask for safe places they can go to do be around people, e.g. coffee shop.

__ Remember, in this step, suicidal thoughts and feelings are not revealed.

[2] See Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008) for a full description of the instructions.

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

__ Instruct patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.

__ Ask *"Among your family or friends, who do you think you could contact for help during a crisis?"* or *"Who is supportive of you and who do you feel that you can talk with when you're under stress?"*

__ Ask patients to list several people, in case they cannot reach the first person on the list. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis.

__ Ask *"How likely would you be willing to contact these individuals*?"

__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Contacting Professionals and Agencies

__ Instruct patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.

__ Ask *"Who are the mental health professionals that we should identify to be on your safety plan?"* and *"Are there other health care providers?"*

__ List names, numbers and/or locations of clinicians, local urgent care services, VA Suicide Prevention Coordinator, VA Suicide Prevention Hotline (1-800-273-TALK (8255))

__ If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 6: Reducing the Potential for Use of Lethal Means

__ The clinician should ask patients which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.

__ For methods with low lethality, clinicians may ask veterans to remove or restrict their access to these methods themselves.

__ Restricting the veterans' access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing for me:

1.
_____

2.
_____

3.
_____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1.
_____

2.
_____

3.
_____

Step 3: People and social settings that provide support or distraction:

1.
_____

2.
_____

3.
_____

Step 4: Contacting Family Members or Friends Who May Offer Help to Resolve a Crisis

1. _____

2. _____

3. _____

Step 5: Professionals or agencies I can contact during a crisis:

1. _____

2. _____

3. _____

4. **Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)**

Step 6: Things I can do to make my environment safe:

1. _____

2._____

LOCAL COUNTY MENTAL HEALTH IN CALIFORNIA
24-HOUR CRISIS INTERVENTION NUMBERS

Alameda County 800-491-9099
Alpine County 800-486-2163
Amador County 888-310-6555
209-223-6412
Berkeley City 510-981-5290
510-981-5244 - Mobile Crisis Team Line
Butte County 800-334-6622, 530-891-2810
Calaveras County 209-754-3239, 800-499-3030
Colusa County 530-458-0520, 888-793-6580
Contra Costa County 925-646-2800, 888-678-7277
Del Norte County 888-446-4408, 707-464-7224
El Dorado County, 530-622-3345 - Placerville/El Dorado
530-544-2219 - South Lake Tahoe Outpatient Clinic
800-929-1955
Fresno County 800-654-3937
Glenn County 800-507-3530
Humboldt County 707-445-7715
888-849-5728
Imperial County 760-339-4504
800-817-5292
Inyo County 760-873-6533
800-841-5011
Kern County 800-991-5272
Kings County 559-582-4484
800-655-2553
Lake County 800-900-2075
Lassen County 530-251-8108
Los Angeles County 800-854-7771
Madera County 559-673-3508
888-275-9779

Marin County 415-499-6666
Mariposa County 209-966-7000
888-974-3574
Mendocino County 800-555-5906
707-463-4396
Merced County 209-381-6800
888-334-0163
Modoc County 800-699-4880
Mono County 800-841-5011
760-924-1740
Monterey County 831-755-4111 (Page - Crisis Team)
Napa County 707-253-4711
800-648-8650
Nevada County 530-265-5811
Orange County 714-834-6900
Placer County 888-886-5401
866-293-1940 – Family and Children's Services
Plumas County 530-283-6307
800-757-7898
Riverside County 800-706-7500
Sacramento County 888-881-4881
San Benito County 831-636-4020
888-636-4020
San Bernardino County 888-743-1478
San Diego County 800-479-3339
San Francisco County 415-781-0500
San Joaquin County 209-468-8686
San Luis Obispo County 805-781-4700
800-838-1381
San Mateo County 650-579-0350
800-273-8255
Santa Barbara County 888-868-1649
Santa Clara County 855-278-4204

Santa Cruz County 800-952-2335
Shasta County 530-225-5252
800-821-5252
888-385-5201
Sierra County 877-435-7137
Siskiyou County 800-842-8979
Solano County 707-428-1131
Sonoma County 800-746-8181
Stanislaus County 209-558-4600
Sutter-Yuba County 530-673-8255
888-923-3800
Tehama County 530-527-5637
800-240-3208
Tri-City Mental Health 866-623-9500
Trinity County 530-623-5708
888-624-5820
Tulare County 800-320-1616
Tuolumne County 209-533-7000
Ventura County 866-998-2243

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

RED NACIONAL de PREVENCIÓN del SUICIDIO
1-888-628-9454
prevenciondelsuicidio.org

Clinical Risk Documentation Tips

1. If you inquire about suicidal and homicidal ideation, your progress note should always indicate that you did and what the client's response was. For example, "client denied suicidal or homicidal ideation at this time." If you do not note that you inquired, it will be assumed that you did not.

2. Provide specific quotes from the clients when possible: "I'm not going to do anything to actively harm myself. I just wish God would take me."

3. When suicidal or homicidal ideation is noted, you should also note the presence or absence of a plan, access to means, and intent. "Although patient reported recurrent suicidal ideation and wishes to die, she did not have a specific plan in mind and stated 'I'm not going to do it.'"

4. When your note raises a serious risk, it should always provide a plan that corresponds with appropriate detail, prudence, and immediacy to the seriousness of the risk. "Patient stated a desire to kill his wife, has been thinking about using his handgun to do so, and recently purchased ammunition. Given the level of risk, I consulted clinical supervisor Jane Addams, LCSW. On the basis of risk, we activated 911, warned the patient's wife by phone call and advised her accordingly, and collaborated with the psychiatric emergency room on assessing patient. They plan to hold patient overnight and I will call and confer tomorrow to provide clinical follow-up."

5. It is always a good idea to have your supervisor or a colleague co-sign the note, particularly if you consulted them at the time and if they conducted their own assessment of the patient. This indicates thoroughness and use of consultation and supervision that is deemed prudent.

6. File risk-related notes immediately electronically or in patient chart so other providers can access the information if and as needed.

Practice Vignette[3]

Your field placement is with a veteran's drop-in or outreach center and you have been assigned to work with Adam.

Adam is a 28 year-old, European American Veteran of the Iraq war where he served in the Marines Special Forces. Although his parents divorced when he was in elementary school, he remained close with his father and brother, and they enjoyed skiing together. His father, Kelly, is strong, stoic and reserved; his mother is very emotional and he feels she has not been emotionally stable enough to be a support to him. Known for his risk-taking and athletic prowess, Adam was a competitive skier in high school. At age 18 , his best friend was killed in a motor vehicle crash after ski practice. Adam was in the car at the time and directly witnessed his friend's death. Following this event, he became silent and withdrawn, eventually giving up competitive skiing.

At age 19, after high school, he enlisted in the Marines and was selected for the Special Forces. Part of an elite security detail, it is suspected that he saw death and killed others in the line of duty. Upon returning home, he was diagnosed with PTSD, drinks heavily, blacks out, appears chronically depressed and hopeless, and frequently punches walls. He does not stay in touch with other veterans or appear to have friends. His girlfriend with whom he lived recently broke up with him and evicted him from the apartment, alleging domestic violence, and his father and stepmother won't let return to their apartment due to his drinking and the presence of their youngest daughter(age 11). His closest support is his stepmother, Darcy.

[3] This video vignette is based on Adam who is featured in Season 8, Episode 2, of Intervention. You may purchase this episode on iTunes or watch it on Netflix.

Discussion Questions:

1. What are Adam's individual and contextual risk and protective factors related to suicide and homicide?

2. Assess Adam for suicidality in dyads.

3. Assess Adam for homicidality in dyads.

4. Draft a safety plan appropriate to the level of risk you determined.

5. How might you protect Adam's safety and those of his loved ones in the intermediate term (i.e. beyond immediately – over the course of, say, 16 weeks of treatment)?

Presentation References

Brown, G.K., Beck, A.T., & Steer, R.A. (2000). Risk factors for suicide in psychiatric outpatients: a 20-year prospective study. *Journal of Consulting and Clinical Psychology*, 68(3), 371-377.

Duplessis, V., Goldstein S., & Newlan S. (2010) Understanding Confidentiality and Minor Consent in California: A Module of Adolescent Provider Toolkit. Adolescent Health Working Group, California Adolescent Health Collaborative. Retrieved on September 14, 2013 from http://www.californiateenhealth.org/wp-content/uploads/2011/06/toolkit-rri-Web.pdf

Core Competencies for the Assessment and Management of Individuals at Risk for Suicide. Retrieved September 14, 2013 from http://www.suicidology.org/c/document_library/get_file?folderId=233&name=DLFE-33.pdf

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Quinnett, P. (2010). Suicide risk assessment competency certification examination. Retrieved June 6, 2011, from http://www.qprinstititue.com.

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Rutgers Center on Public Security (2011). Risk Factors of Murder and Non-Negligent Manslaughter. Research Brief Series Dedicated to Shared Knowledge (15, March).

Original Sample Safety Plan template may be retrieved from http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf

Stanley, B. & Brown, G. (2008). Safety Plan Treatment Manual to Reduce Safety Risk: Veteran Version. Retrieved September 14, 2013 from www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.doc

U.S. Public Health Service (1999). The Surgeon General's Call to Action to Prevent Suicide. U.S. Department of Health and Human Services, Washington, D.C. Available at: http://profiles.nlm.nih.gov/ps/access/NNBBBH.pdf

Portions of these materials were adapted from materials originally developed by Peter Manoleas, LCSW.