PROVIDED AS INFORMATION ONLY
ALWAYS CONSULT LEGAL ADVICE

MANDATORY REPORTING

MANDATORY: Law compelled breaches of confidentiality are related to mandatory reporting and the release of information.
OTHER DISCLOSURE INFO: If the court orders the counselor to disclose information, the counselor must comply or be subject to penalty, even incarceration. Also, if the client waives the right to privacy (or any aspect of privacy), the counselor must concur (note: signing insurance forms gives consent to disclose specific information).
Keep in mind that a waiver from the client does not give the counselor "carte blanche" to release information indiscriminately.
States vary in their interpretation of the doctrine of duty to warn, so counselors must be familiar with their state laws in order to determine their legal responsibilities. Some states reject it, some adhere to it, and some modify it. Knowing your state's statutes is critical. ***Make sure you document and date who else you informed, what phone calls you made, who you consulted and the results of these contacts.***

HOMICIDE RISK

Since it is impossible to predict with 100% accuracy dangerousness ahead of time, violation of a client's confidentiality must be undertaken with great care and in consultation with others. The art of counseling involves learning to discern what a client is really saying. When someone says, "I wish I (or someone else) was dead" are they talking suicide or homicide or just expressing frustration with their current stress levels or relationship difficulties? How do we distinguish between the client who vents in scary ways and those who may carry out their threatening words? Assessing seriousness and imminence of danger is fraught with trouble.

THE BEST PREDICTOR OF FUTURE VIOLENCE IS A HISTORY OR PATTERN OF PAST VIOLENCE.

1. Good documentation is essential in every case, but with dangerous and threatening clients, it's critical.
2. Make sure you have a treatment plan and you update and date it regularly.
3. In your case notes record specifically what a client said, your assessment of the threat, what you did, and why you decided to do it.

THE VIOLENT-ANGRY-IMPULSIVE PERSON WILL…

- Shows a history of violent and assaultive behavior—assault, hitting and injuring others, destroying or damaging property, and injury to self for such action;
- Reveals impulsive anger or rage that is explosively triggered by various people or events—the person quickly gets out-of-control and becomes destructive to things or people and relationships;
- Shows a tendency to hurt others and vengefully react when angry—using cutting, harmful words, hiding or destroying things special to the person who is the focus of one's anger;
- Projects blame onto others—is critical and condemning of others, while being unable to receive and reactive against any criticism from others;
- Justifies anger and harmful expression, unable to forgive, tending to hold grudges and resentments over a long period of time;

- Suppresses anger—deny anger in the face of obvious evidence—flushed face, clenched teeth and muscles, harsh and loud tone of voice, threatening posture;
- Represses anger—deny anger problems (contrary to history) without obvious anger signals—passive-aggressive, aloof, sarcasm-cynicism, conflict-avoidant; and
- Shows associated physical complaints and symptoms—gastric-intestinal distress, ulcers, spastic colon, headache, hypertension, and cardiac irregularities.

SUICIDE RISK

There is no pure legal duty to prevent suicide—the duty is to intervene appropriately—the law recognizes limits in the ability to stop a determined person from suicide.

The duty to intervene is judged according to the degree of suicidal risk exhibited by a client and the counselor's ability to accurately assess and control that risk. The counselor's liability increases as the risk of suicide increases and the counselor is able to foresee and control the client's actions. Since the clinician in an inpatient facility can control the patient's behavior more than in an outpatient setting, liability is greater when suicide occurs in a hospital, day treatment, or residential care facility.

Law and Ethics in Suicide Intervention: Suicide is not only one of the riskiest cases for a counselor clinically and spiritually, but legally as well. Professional clinicians are increasingly at legal risk for the suicide of their clients and patients. Indeed, the clinician working in an inpatient or restrictive treatment setting has a strong duty to intervene in the life of someone judged to be a substantial risk for suicide. In contrast, a pastor in a church setting may be ethically and morally, but not legally, bound to a duty of suicide intervention.

SUICIDE ASSESSMENT: Assessment of suicidal risk involves gathering information from multiple sources across a number of key variables.

The essential two-part question of suicide assessment is: Is this person at risk for committing suicide, and If so, how serious is the risk?

The competent counselor will assess this risk according to history, trait, mood, personality, and situational factors. Begin counseling with assessment of suicide risk. The easiest way to get information about suicide risk is to ask questions at the beginning of counseling. We incorporate questions about suicide (and homicidal and assaultive behavior) in our clinical intake forms. This gives direct access to these issues at the start of professional relations.
Structuring assessment this way and addressing these questions on initial interview puts clients more at ease as they see it as part of the routine we follow with all new clients.

Evaluate suicide risk across the seven key variables that follow. Risk for suicide increases according to:

- Past suicide attempts and their seriousness
- Communication of intent/denial of intent
- Assessing the violent-angry-impulsive person

Professional counselor liability for suicide cuts across two issues:

1. The setting in which the crisis arises and the nature of the alleged harm
2. Whether it involved failure to take preventive action to avoid suicide or whether the clinical behavior caused the suicide