Attention UB Ministers

In our continuous efforts to support each Minister and each Ministry program, we are once again presenting an important legal aspect to incorporate in your practice. As always, we are not offering legal advice and urge you to check your local laws and requirements. Please read the following article and begin to implement these steps in your work with each client.
Thank you for your dedication to UB and the important work you do in the World.

Excerpted from the Autumn 2018 issue of *UB GoodNews*

LIMITS TO CONFIDENTIALITY

By Rev. Gregory Fisher

As a minister who works with a wide variety of clients, it is important to explain our position on LIMITS OF CONFIDENTIALITY up front. We must make these limits clear from the first minute of the first meeting. We cannot wait until we are challenged because the client has shared something with us that must be reported because he or she thought that "confidentiality" would prevent us from doing so. Here is exactly what we must say:

> *"I will hold all information shared with me as sacred and confidential EXCEPT:*
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> *#1. If you mention or allude to a possible suicidal act in the present or future by you or by someone you know,*
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> *#2. If you mention or allude to a possible homicidal act in the past, present or future against any individual by you or by someone you know,*
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> *#3. If you mention or allude to a possible act of abuse in the past, present or future against a child or a minor by you or by someone you know,*
>
> *#4. If you mention or allude to a possible act of abuse in the past, present or future against an elderly or disabled person by you or by someone you know.*
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> *I am bound by law to report these things and; therefore, they are outside the express limits of our confidentiality agreement. Do you understand?"*

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All of these are reportable actions, and must be conveyed at once to the local authorities to take appropriate action. In the instance of possible child abuse, the Department of Children's Services (or whatever the child services agency is called in your locale) ask us not to "weigh or judge the validity or severity of the information." We must simply report it ASAP. The same applies to the other issues of suicide, homicide and elder/disabled abuse.

We must understand also that "alludes to" includes second or third (or more) hand knowledge and reports. For example, if a client states that their friend's mother told him that someone told her that someone was having inappropriate contact with kids (or any other of the reportable actions), we report it! We don't question if it is true or not. It's not up to us to determine that.

I can relate here a story that I'm aware of because it happened to one of my friends. She was working with a client and the client's ten-year-old son. The mother recounted that her sister had stated that she believed the son was having inappropriate contact with her five-year-old daughter. The mother told her sister that it was ridiculous and accused her of lying and not loving her son. She then took a long part of her session criticizing her sister for being such a trouble maker and nuisance. She suggested that she was going to detach from her sister and her niece. My friend mulled it over after the session and determined that she didn't need to report the statements because they had been mentioned to her as an example of how the client's sister was lying and exacerbating the problems she was having with her son. The problem? The sister reported her nephew to the abuse hotline for sexually assaulting her daughter. The state investigated and found that the boy WAS abusing his cousin. The client informed my friend's supervisor that she had told my friend in a session. My friend lost her license.

Here's what's important for us to know: don't THINK, just REPORT! We don't know enough to process the information or conduct an investigation before reporting the information, **and it's not our job**. We report what we hear when what we hear it. It's the authorities' job to investigate and determine if there is a problem.

Waiting and thinking puts us at risk and also—much worse—puts any potential victims at risk, as in the example I've given.

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Explaining these limits to confidentiality at the very first meeting sets the expectation. For most of our clients, this will seem like a silly exercise—they have no such issues and may even be perplexed that we have raised the issue. But our insistence on discussing these situations up front clearly demonstrates our professionalism, and it avoids any misunderstanding should an issue emerge as we move forward with helping our clients.

S.L.A.P. ASSESSMENT FOR SUICIDALITY

While I want to reiterate that it isn't our job to investigate the validity of a reportable concern, sometimes a client may begin talking in a manner that becomes curious and may indicate that they are heading toward an act of self-harm or even suicide. The client hasn't expressed a statement of intention, but we are hearing something that seems potentially dangerous. We're thinking we need to question further to know how seriously to take the threat. Now what?

There is a suicidality assessment that can be useful in considering the level of risk you are encountering with a client (or any person) who has alluded to a possible self-harm. A client mentioning that they wish they could die (or wish they could fall asleep and not wake up) or that they have considered killing themselves, does not mean that they are intending to do so. Here are some questions that can help you determine if there is any potential that the client is actually suicidal.

S = Specificity: Have they considered suicide to the extent that they have an actual plan? Is the plan specific? Do they have a mode of death in mind, a date, a time, a place? The more specific, the more concerning the threat may be.

L = Lethality: Is the mode of death the client may be considering actually lethal? If enacted, would it actually cause death?

A = Availability: Is the mode of death available? Have they made plans to procure it? Can they?

P = Preventability: Are there limitations or preventions in place that will keep the plan from being enacted? Are there people around who would be barriers to the act taking place? Is there a location where the client could carry out the plan?

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So, a client who tells you that they are planning to end their life the next morning (specific) in a remote area of the woods (more specific, no preventions) by shooting themselves in the head with a gun (extremely specific and lethal) that they just purchased and have loaded in the car (specific, lethal, available, no preventions) is at greater risk than someone who tells you that they are thinking about ending their life, but they haven't considered how, where, or when (not specific, possibly not lethal, possibly not available, possibly preventable). Or one who says they are going to take pills (specific and potentially lethal), but don't have any pills or access to pills (not available and preventable). Of course, this also doesn't consider that they will come up with a very specific, lethal, available and unpreventable plan as soon as they leave your office.

The SLAP Assessment helps us determine the level of risk in the moment; but again, any mention of suicide needs to be taken seriously. It is a myth that people who commit suicide haven't told anyone, or that people who tell someone are only looking for sympathy. More than 85% of people who attempt suicide or are successful in killing themselves **have** told someone before carrying out their plan.

Perhaps your client is telling you because they are seeking counseling, support and help, and perhaps you can be effective in ameliorating their situation so that the suicide is preventable. But if you have any doubt, and if the SLAP Assessment gives you an indication that they may be able successfully to complete their attempt, report the conversation to the authorities and let them decide how to proceed. Also, in this case, you should inform the client that you are going to call for assistance. Stay with the client until help arrives.

Calling for assistance can look like notifying a treating professional who is more involved in the client's mental health than you; for example, a psychiatrist. It can mean calling a mobile crisis response team or crisis center. Or it can mean calling for emergency services. Dialing 911 will usually get a rapid and appropriate response—usually law enforcement will be alerted and will escort the client to emergency services. It is not typical for an ambulance to be summoned, but the response may vary with local statutes and protocols. <u>You should learn and be familiar with those statutes and protocols for your area</u>.

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In any case, make sure that the responding personnel are aware of the story you heard and your assessment of the risk prior to making the call.

It is not uncommon for people to change their story after they become concerned that there are going to be consequences that may be difficult or that their very real desire to end their life is going to be thwarted. Ultimately, it will be up to the treating professionals and perhaps even the client to determine what needs to happen next. However, it is important that you be aware that someone who is suicidal may lose the ability to make their own decision temporarily, and will be committed involuntarily for mental health treatment to prevent the suicide.

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Suicide does not end the chances of life getting worse. Suicide eliminates the possibility of it ever getting better.

Vic Fuentes