Ethical Considerations in the Assessment and Management of Suicide Risk

Introduction

Suicide is the tragic outcome of a diverse interplay of biological, psychological, and social factors. Suicide affects all people and has long been considered a complex, but preventable, cause of disease burden throughout the world. Despite improvements in awareness and treatment, suicide continues to account for 1 million deaths annually—one life lost every 40 seconds. Suicide occurs in the general population at a rate of 11.3/100,000 in the United States. Suicide attempts occur even more frequently. For every death by suicide, the Institute of Medicine (IOM) reports that an additional 25 nonfatal suicide attempts (100-200 for youth) are estimated to occur. Suicide attempts are associated with approximately 500,000 emergency room visits every year in the United States alone. Risk for suicide cuts across mental disorders, socioeconomic status, age, and gender, and "psychological autopsy" studies indicate that nearly all suicide decedents have at least one psychiatric disorder at the time of death.

The detection, prediction, and management of suicidality present a diverse array of ethical challenges. Suicidal behaviors, now defined in a standardized nomenclature, exist on a spectrum, ranging in severity from suicidal ideation to suicide attempts to death by suicide. In seeking to prevent self-harm, clinicians ideally will use what have emerged as "best practice" techniques to assess suicide risk and intervene if necessary, yet fear of losing a patient to suicide, and worry surrounding malpractice claims, are significant concerns reported by clinicians. This may result in two kinds of responses: 1) a "better safe than sorry" approach, where suicidal risk is overestimated, and 2) an avoidant or dismissive approach, where risk is inadequately assessed, and thereby underestimated. An overestimation of suicide risk may deprive a patient of their rights and may misuse clinical resources. On the other hand, an underestimation of suicide risk may jeopardize the safety of the patient and increase the liability of the provider. Inaccurate assumptions about best practice treatment of suicidal behaviors may also heighten the fear and worry of clinicians. For example, despite advances in evidence-based suicide risk assessment and treatment, an inaccurate belief may persist that hospitalization is the optimal clinical response to a distressed patient. This is a problem, given the absence of evidence supporting the enduring efficacy of acute hospitalization, particularly compared to randomized controlled behavioral treatment trials reporting reduction of risk using psychosocial outpatient interventions for suicidal behaviors. Dispelling myths, or inaccurate beliefs that may result in harmful consequences to the patient or clinician, is thus critical within a discussion of ethical considerations on this topic. Ethically and legally, best practice and reasonable care should likewise be distinguished from the prediction of suicide, or the legal construct of foreseeability. Given its low rate of occurrence, suicide is not an outcome that clinicians can reliably predict. Rather, evidence-driven approaches and established guidelines in the assessment and management of suicide risk represent the optimal ethical approach in caring for patients at risk for suicide.

Several cardinal medical ethical principles in psychiatry shape ethical approaches to the care of patients at risk for suicide and inform "best practices" in this aspect of clinical care:

- **Respect for Persons** - a deep regard for an individual's worth and dignity;
- **Autonomy** - self-governance;
- **Beneficence** - the responsibility to act in a way that seeks to provide the greatest benefit and, for this reason, the notion of clinical excellence is an imperative in fulfilling this principle.
- **Fidelity** - faithfulness to the interests of the patient;
- **Nonmaleficence** - primum non nocere ("first, do no harm");
- **Veracity** - the duty of truth and honesty;
Best Practices in Suicide Risk Assessment and Management

Approaching the Patient - Informed Consent

Informed consent to treatment and risk management may be defined as informing the patient of all procedures that will be used in the evaluation and management of suicide risk, clinical decision-making, and emergency assessment and referral practices. Like evidence-based psychosocial interventions for suicidal behaviors, this process should be highly transparent, collaborative, and initiated at the onset of treatment to disclose ethical and legal responsibilities of the provider, limits to confidentiality, and to enhance understanding of treatment ground rules. In deeply respecting the rights and dignity of the individual, this process strongly supports the Autonomy of the patient, as well as Respect for Persons.

Informed consent to suicide risk management can be collaboratively described as working together to keep the patient safe. Such language compassionately stresses the equal importance of both the patient and clinician in safety planning. Assessment procedures, routinized clinical-decision making, and specific circumstances prompting an emergency referral should be made unambiguous as part of the informed consent process. Adequate time and effort should be devoted to answering questions and confirming understanding of such procedures. For example, a clinician can inform the patient about questions he or she may expect in a suicide risk assessment, under what circumstances they will be asked, how this information will be used, and any limits to confidentiality. The collaborative, transparent aspect of this approach embraces principles of Privacy and Veracity, as well as the dignity and the self-governing rights of the patient. Beneficence is also represented in informed consent, given that explanation of best-practice assessment both standardizes assessment and routinizes clinical decision-making. In this way, informed consent maximizes benefits, while minimizing risks to the fullest extent possible.

An opportunity to strengthen the therapeutic relationship is inherent to this process. Suicidal ideation is associated with significant distress, yet patients may be reluctant to disclose symptoms because of fear of stigma or judgment. This may promote shame, isolation, and secrecy in treatment. Informed consent of risk assessment and management has the potential to directly address these fears and compassionately correct harmful misperceptions, if present. Providing diagnostic feedback about risk (i.e., education that suicidal ideation is a symptom of depression, among a constellation of other diagnostic criteria) may empower the patient with accurate information about his or her symptoms, diagnosis, and treatment plan, whereas education about suicidal symptom severity and risk categorizations may address fears of involuntary hospitalization. The collaborative and transparent nature of assessments may here again be emphasized, with risk categorizations delineated (e.g., minimal, mild, moderate, serious, imminent risk). The way in which risk categorizations guide decision-making may also be made explicit to clarify questions about circumstances that would prompt emergency referrals (e.g., informing the patient that referral for involuntary services will only be pursued when risk is judged to be serious/imminent, the patient is offered emergency services on a voluntary basis, and he or she refuses voluntary services).

Undertaking the Next Steps - Assessing and Managing Patients At-Risk

The ability to perform an adequate assessment of suicidality and to manage patients who are at risk for suicide is an essential clinical skill for psychiatrists and other mental health professionals. Because clinical excellence is vital to fulfilling one’s professional obligations, the ability to assess and manage high-risk patients is also an ethical commitment for psychiatrists and other practitioners. Psychiatric practitioners, acting on knowledge from training years ago, may rely on inadequate interventions, such as the “no-harm contract,” and may not be as knowledgeable about empirically supported behavioral treatments for suicidal behaviors. Best practice techniques in standardized suicide risk assessment and evidence-based
clinical decision-making are strongly rooted in clinical science, and emerging standards that derive from the field of suicidology. Modern clinical practice requires knowledge and use of 1) suicide risk factors and warning signs; 2) standardized suicide risk assessment frameworks, risk categorizations, and decision-tree rules for outpatient management; and 3) suicidal symptom severity scales. For a list of evidence-based guidelines and materials, we refer clinicians to those listed in Figure 1: Resources.

Figure 1: Resources

Emergency Hotlines

- The National Suicide Prevention Lifeline; 1-800-273-TALK (8255); http://suicidepreventionlifeline.org

Physician Performance Improvement Clinical Module for MOC


Articles


Books


Evidence-based suicide risk assessment frameworks structure the assessment process in an alliance-based and non-defensive manner. Symptom measures (clinician administered or self-reported) are straightforward to use, and they aid the clinician in assessing the severity of suicidal symptoms across empirically derived domains (i.e., onset, duration, frequency, and intensity of suicidal ideation; suicidal intent and planning; history of suicidal behaviors; access to means for a suicide attempt). The structure, severity, and intensity of symptoms translate into quantifiably different risk categorizations, and may be reliably addressed using established measures. For example, the Columbia-Suicide Severity Rating Scale (C-SSRS) is a brief measure of suicidal ideation and behaviors that may be used in clinical practice to assess and regularly monitor suicide risk. It has excellent psychometric properties and is accessible and available in 103 languages; administration training is also offered in its use for research and clinical practice (Figure 1). Among those at high risk for suicide, the use of evidence-based interventions, particularly those informed by cognitive-behavioral frameworks, is associated with a significantly decreased risk for suicide attempts, in some cases, reducing risk by half.8,16 In outpatient management of suicide risk, safety planning may be used to identify emergency resources, as well as cognitive and behavioral coping strategies, for the patient to elicit during a suicidal crisis.

Safety planning is highly tailored to the individual and is patient-driven, preferably with the patient identifying and recording his or her own internal coping strategies, in addition to mental health resources (e.g., contact information for local hospitals and emergency clinics, 24-hour crisis hotlines). Safety planning should be comprehensive, concise, and easily accessible and available to the patient. As with evidence-based psychosocial psychotherapies, safety planning is collaborative, transparent, and stresses agency on the part of the patient during the crisis. This honors the Autonomy of the patient, Respect for Persons, as well as Nonmaleficence, in protecting a patient from harm.

Throughout the processes of suicide risk assessment and the management of patient safety, wise and thoughtful clinicians use additional strategies to uphold the highest standards of care: 1) consultation with colleagues, and possible use of decisions by consensus, for difficult or complex cases; 2) regular documentation (i.e., risk level, action taken, safety planning); 3) diligence surrounding continuity of care, given that attrition in treatment is common, yet dangerous, for this high-risk group; and 4) continued education in suicidology.

Beyond these strategies, mental health professionals carry an implicit ethical obligation to work to dispel myths about suicide, raise awareness about suicide prevention, and remove language that may be inaccurate, misleading, and potentially harmful to patients (9). Removal of harmful language related to suicidal behaviors, and dissemination that promotes suicide prevention, values the principles of Autonomy,
Respect for Persons, Beneficence, and Nonmaleficence. Deconstructing misunderstandings about suicide is a clear expression of these ethical ideals. For instance, the myth that suicidal "gestures" should be "ignored" rather than "gratified" with a clinical response should be challenged-a dismissive approach to risk assessment is always inappropriate.

When a patient endorses or behaves in a manner that suggests suicidality, it must be taken seriously and should be recognized as an opportunity for intervention that may prevent loss of life. Another harmful myth includes the belief that asking about suicidal thoughts and plans may produce suicidality-that questions regarding suicide create "iatrogenic" conditions.

This is not grounded in clinical science. Research suggests that assessing suicidal thoughts and risk regularly and frequently does not exacerbate symptoms. Myths like these may discourage questioning about suicidal ideation and increase stigma and, in this way, thwart intervention and suicide prevention efforts. To help clarify optimal ways of addressing these difficult issues with patients, particularly with subgroups that may have heightened risk, several professional and advocacy organizations have worked together to propose guidelines for reporting on suicide to prevent language or nomenclature that may sensationalize or stigmatize suicide or result in suicide contagion. These guidelines, available online by the Suicide Prevention Resource Center, are an excellent resource for clinicians. One recommendation from such guidelines, which may be easily adopted into our daily nomenclature, is removal of the term "committed suicide" and replacement with "death by suicide." Rationale is based on the stigma often tied to descriptions of suicide, in this case nuanced by negative connotations of the verb "committed," as it is typically only used to describe sins or crimes.

Dissemination of accurate, nonjudgmental information regarding suicide and its prevention is thus an expression of professional Integrity as well as fulfillment of the obligations of Beneficence and Nonmaleficence. These foundational principles are embraced both in continuing education (e.g., CE credits, curriculum development of residency training) and promotion of suicide prevention awareness.

Case Vignette

Background

Jane is a 46-year-old physician employed full-time at an emergency room, where she has worked for 2 years. She very recently ended her marriage of 8 years and has no children. She began feeling depressed around the time of her divorce 6 months ago and sought treatment from a psychiatrist. Jane reports having only a few friends in the area and becoming more isolative following the separation. She states that she felt depressed only one other time in her life—in college, for approximately 1 year.

Diagnosis and Treatment

Jane was diagnosed with major depressive disorder-recurrent type with moderate severity—and initiated weekly psychotherapy with a psychiatrist. Jane was prescribed an SSRI, as well as a hypnotic for insomnia. Difficulty falling asleep began during her marital separation. She reports significant distress about the insomnia, which appears worsened by her rotating, extended shift work schedule. Jane recently reported thoughts of suicide—although she quickly stated that she would never act on such thoughts. This prompted questions from her psychiatrist about the frequency and quality of such thoughts, as well as her history of hospitalizations and past suicidal behaviors. She reported that she had been hospitalized once, when she was 20 years old, following a suicide attempt, but noted that she was "all screwed up back then." The method of the attempt was by overdose, which required medical treatment. Regarding her current symptoms, Jane stated that on several occasions in the past week she thought about driving off the road and "ending it all." Her psychiatrist asked when the symptoms began, and whether she had made plans for a suicide attempt. Jane denied any plans or preparation for an attempt, and said the thoughts began after signing her divorce papers several weeks ago.
During a session with the psychiatrist, Jane was asked to identify factors that appeared to prompt the suicidal thinking and to identify reasons for living. Jane reported that her divorce papers were a clear trigger, that she felt like a failure in her marriage. She said she felt hopeless about the future. In the remainder of this session, distorted thoughts were challenged and restructured using cognitive behavioral therapy, and the psychiatrist felt that Jane handled this intervention well. When she was asked to identify reasons for living, however, she had greater difficulty. After some time, she identified minimal enjoyment of work and love for her parents as reasons. The session ended with assessment and treatment planning. The psychiatrist asked Jane to rate the severity of her suicidal thoughts, which she described as "mild." He asked her to agree to call him directly if her symptoms worsened and confirmed their appointment for next week. Jane agreed and appeared amenable to this plan.

Case Discussion

In this difficult case, the psychiatrist appears to have had some success in establishing a therapeutic dialogue with the patient. Given the nature of the concerns, the psychiatrist could have taken additional time, however, to talk with the patient about the process of evaluating suicide risk and how they, together, would approach the next steps in understanding her concerns. Informing the patient of this process at the start of treatment presents the opportunity to assess and categorize risk level from the outset of therapy and lay the foundation for ongoing monitoring of symptoms. This conversation, which may be understood as fostering the therapeutic relationship as well as fulfilling informed consent, may promote earlier risk assessment and detection, as well as opportunity to reduce distress and suffering. Jane volunteered information of a deeply personal nature regarding her suicidal thoughts—which she had already been experiencing for 1 week and had contemplated acting on them. Explicit description of risk assessment and management procedures helps both the patient and the clinician, and if introduced at the beginning of treatment, may improve communication and provide structure to assessment and treatment. This "informed consent" conversation may be presented as a standard part of the diagnostic assessment process, even if the patient does not endorse suicidal thoughts initially.

In response to Jane's endorsement of suicidal thinking, the psychiatrist expressed compassion and inquired directly about the quality and duration of symptoms. The psychiatrist intervened by addressing hopelessness and reasons for living. This intervention was valuable. Suggested additional next steps are noted below.

A formal and comprehensive evaluation of risk factors and suicide warning signs is recommended in this situation. Numerous suicide risk factors are present: divorced marital status; occupation (physician); a recent stressful event or loss (divorce); no children; and a past suicide attempt history. Jane also reported a number of suicide warning signs that should prompt a standardized suicide risk assessment: intense and pervasive suicidal ideation; social isolation; hopelessness; and disturbances in sleep. Addressing these factors would best inform assessment, Jane's risk level, and the intervention process. For example, Jane's risk level is raised by the severity of her depression, as well as the presence and severity of past suicidal behaviors, in this case, a suicide attempt that was more lethal in nature (i.e., resulting in physical injury requiring medical attention). Assessing the severity of current suicidal symptoms would have been helpful and important for these reasons. These steps can be readily accomplished using a brief, standardized scale (such as the C-SSRS). This would allow the psychiatrist to easily quantify the severity of symptoms and risk level to guide clinical decision-making and documentation of action taken.

Given Jane's combination of risk factors and warning signs, the recommended best practice intervention would include construction of a safety plan in session. Although the psychiatrist's response was in many ways consistent with, and adaptable to, a safety plan (i.e., explicitly addressing hopelessness and reasons for living; asking Jane to call if symptoms worsen and providing his number as a resource), a more formalized intervention is recommended. As a collaborative process, this involves construction of a safety plan tailored to the patient's individual risk level and coping strategies. A small index card may be used to list emergency resources in the local area, which would include the clinician's contact information, as well as free 24-hour crisis hotlines (e.g., National Suicide Prevention Lifeline, 1-800-273-TALK), nonemergency support resources (e.g., parents and close confidants whom the patient may call if in need of social support), as well as internal coping strategies (e.g., pleasurable activities, adaptive cognitions, and
behavioral strategies that promote coping). Safety planning may also include a listing of protective factors that the patient may draw on as a source of additional support. Because Jane identified closeness to her family as a reason for living and a source of hope, the clinician might consider encouraging Jane to reach out, as part of her safety plan, about how she has been feeling. Documentation of all of the above assessment, risk level, and action taken is recommended.

As a safety precaution, limiting access to means for a suicide attempt would also be recommended in the case of Jane. She has a history of overdose, yet was prescribed a hypnotic for treatment of her insomnia. This is contraindicated. Avoidance of medications with overdose potential is recommended whenever risk is judged to be elevated. Assessing access to medications with potential for overdose, and limiting them wherever possible, is also suggested.

Last, when describing her suicide attempt, Jane used language that may be viewed as derogatory or shameful. In addressing suicide risk assessment, the nature and prevalence of suicidal behaviors, and evidence-based treatments, there may be opportunity to correct misconceptions about suicide and improve treatment. As a collaboration between the patient and the physician, this process facilitates transparency and communication that support the highest level of care.

References


12. Rudd MD; Joiner T; Brown GK; Cukrowicz K; Jobes DA; Silverman M; Cordero L: Informed consent with suicidal patients: rethinking risks in (and out of) treatment. *Psychotherapy (Chic)* 2009; 46:459-468


17. Stanley B; Brown G; Brent DA; Wells K; Poling K; Curry J; Kennard BD; Wagner A; Cwik MF; Klomek AB; Goldstein T; Vitiello B; Barnett S; Daniel S; Hughes J: Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *J Am Acad Child Adolesc Psychiatry* 2009; 48:1005-1013


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**Ethics Codes, Laws, and Regulations**

Ahealth.com Editor’s Note:

Practitioners are governed by state laws and regulations and by codes of ethics. All major organizations in the mental health professions have adopted a code of ethics. Readers are encouraged to examine their state laws and regulations as well as provisions of the ethics codes related to the topics in this program. Below is information about some of the ethical issues and state laws and regulations in California and Florida related to topics discussed in this program.

**Ethics Codes:**

APA: Ethical Principles of Psychologists and Code of Conduct

Code of Ethics of the National Association of Social Workers
http://www.socialworkers.org/pubs/code/code.asp

California Association of Marriage and Family Therapists (CAMFT)
http://www.camft.org/CamftBenefits/whatscamft_ethnic1.html

American Association for Marriage and Family Therapy Code of Ethics
http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx

American Counseling Association Code of Ethics and Standards of Practice
California Law and Ethical Standards

Accepted Ethical Standard for Psychologists

Pursuant to Section 2936 of the California Business and Professions Code, the American Psychological Association's, Ethical Principles of Psychologists and Code of Conduct, is the accepted ethical standard applicable to the practice of psychology in California.

Section 2936 states as follows:
2936. The board shall adopt a program of consumer and professional education in matters relevant to the ethical practice of psychology. The board shall establish as its standards of ethical conduct relating to the practice of psychology, the "Ethical Principles and Code of Conduct" published by the American Psychological Association (APA). Those standards shall be applied by the board as the accepted standard of care in all licensing examination development and in all board enforcement policies and disciplinary case evaluations.

To facilitate consumers in receiving appropriate psychological services, all licensees and registrants shall be required to post, in a conspicuous location in their principal psychological business office, a notice which reads as follows:

"NOTICE TO CONSUMERS: The Department of Consumer Affair's Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the board on the Internet at www.psychboard.ca.gov, by calling 1-866-503-3221, or by writing to the following address:

Board of Psychology
1422 Howe Avenue, Suite 22
Sacramento, California 95825-3236"

The APA Ethical Principles of Psychologists and Code of Conduct provides, in part, as follows:

Principle A: Beneficence and Nonmaleficence
Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons and the welfare of animal subjects of research. When conflicts occur among psychologists' obligations or concerns, they attempt to resolve these conflicts in a responsible fashion that avoids or minimizes harm. Because psychologists' scientific and professional judgments and actions may affect the lives of others, they are alert to and guard against personal, financial, social, organizational or political factors that might lead to misuse of their influence. Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work.
Principle E: Respect for People's Rights and Dignity
Psychologists respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality, and self-determination. . . .

3.04 Avoiding Harm Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable.

. . .

3.10 Informed Consent
(a) When psychologists conduct research or provide assessment, therapy, counseling or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

(b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.

(c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding.

(d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 8.02, Informed Consent to Research; 9.03, Informed Consent in Assessments; and 10.01, Informed Consent to Therapy.)

3.11 Psychological Services Delivered to or Through Organizations
(a) Psychologists delivering services to or through organizations provide information beforehand to clients and when appropriate those directly affected by the services about (1) the nature and objectives of the services, (2) the intended recipients, (3) which of the individuals are clients, (4) the relationship the psychologist will have with each person and the organization, (5) the probable uses of services provided and information obtained, (6) who will have access to the information, and (7) limits of confidentiality. As soon as feasible, they provide information about the results and conclusions of such services to appropriate persons.

(b) If psychologists will be precluded by law or by organizational roles from providing such information to particular individuals or groups, they so inform those individuals or groups at the outset of the service.

4.01 Maintaining Confidentiality
Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

4.02 Discussing the Limits of Confidentiality
(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)
(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.

(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

Florida Clinical, Counseling, and Psychotherapy Services

Accepted Ethical Standard for Psychologists

The American Psychological Association’s, *Ethical Principles of Psychologists and Code of Conduct*, is also the accepted ethical standard for Florida psychologists. It is recommended that Florida psychologists review the APA ethics code provisions referenced above.

Grounds for Disciplinary Action

Pursuant to Chapter 490, Florida Statutes: Psychology, s. 490.009, and Chapter 491, Florida Statutes: Clinical, Counseling, and Psychotherapy Services, s. 491.009, grounds for disciplinary action against a licensed psychologist, clinical social worker, marriage and family therapist, and/or mental health counselor include, but are not limited to, the following:

- Failing to perform any statutory or legal obligation placed upon a person licensed under this chapter.
- Making misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed under this chapter.
- Failing to maintain in confidence a communication made by a patient or client in the context of such services, except as provided in s. 490.0147.

Confidentiality

Florida addresses confidentiality and privileged communications in s. 490.0147 and s. 491.0147.

490.0147. Confidentiality and privileged communications.—Any communication between any person licensed under this chapter and her or his patient or client shall be confidential. This privilege may be waived under the following conditions:

1. When the person licensed under this chapter is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by the patient or client, in which case the waiver shall be limited to that action.

2. When the patient or client agrees to the waiver, in writing, or when more than one person in a family is receiving therapy, when each family member agrees to the waiver, in writing.

3. When there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society and the person licensed under this chapter communicates the information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.