Reamer and Conrad's Essential Steps for Ethical Problems Solving

1. DETERMINE whether there is an ethical issue or/and dilemma. Is there a conflict of values, or rights, or professional responsibilities? (For example, there may be an issue of self-determination of an adolescent versus the well-being of the family.)

2. IDENTIFY the key values and principles involved. What meanings and limitations are typically attached to these competing values? (For example, rarely is confidential information held in absolute secrecy; however, typically decisions about access by third parties to sensitive content should be contracted with clients.)

3. RANK the values or ethical principles which - in your professional judgment - are most relevant to the issue or dilemma. What reasons can you provide for prioritizing one competing value/principle over another? (For example, your client's right to choose a beneficial course of action could bring hardship or harm to others who would be affected.)

4. DEVELOP an action plan that is consistent with the ethical priorities that have been determined as central to the dilemma. Have you conferred with clients and colleagues, as appropriate, about the potential risks and consequences of alternative courses of action? Can you support or justify your action plan with the values/principles on which the plan is based?

5. IMPLEMENT your plan, utilizing the most appropriate practice skills and competencies. How will you make use of core social work skills such as sensitive communication, skillful negotiation, and cultural competence? (For example, skillful colleague or supervisory communication and negotiation may enable an impaired colleague to see her/his impact on clients and to take appropriate action.)

6. REFLECT on the outcome of this ethical decision making process. How would you evaluate the consequences of this process for those involved: Client(s), professional(s), and agency (ies)? (Increasingly, professionals have begun to seek support, further professional training, and consultation through the development of Ethics Review Committees or Ethics Consultation processes.)

Suicide and Ethics Case Study: Jane

Jane was diagnosed with major depressive disorder— recurrent type with moderate severity—and initiated weekly psychotherapy with a clinician. 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 clinician 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 clinician 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 clinician, 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 clinician 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 clinician 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.

Key Questions:

1. What did the clinician do well? Identify at least three things.

2. What could the clinician have done better – from a clinical AND ethical perspective? Identify at least two things.

Patient Safety Plan Template

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

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

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

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Template (Stanley & Brown, 2008)

Instructions for Using Patient Safety Template

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.

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, 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 patient to remove or restrict their access to these methods themselves.
__ Restricting the patient's access to a highly lethal method should be done by a designated, responsible person—usually a family member or close friend, or the police.

SMART Plan of Action for Suicidal Clients

Develop a plan of action. These are not necessarily in a specific order.

	Primary focus	Objectives	Action examples
S	**Small**	Keep interventions small, concrete and behavioral.	"I'd like for you to put the gun down." "Would you eat a meal and take a nap before you do anything else?"
	Specific	Specifically, define what you will do, and what the client will do.	"You'll call the VA tomorrow with the referrals that I've given you." "You want someone who will listen [as opposed to "You want to be happy."]
	Safety Plan	Get a commitment from client that he/she will not hurt self before the Crisis Center.	"If at any time in the next 24 hours, if you begin to feel like hurting yourself, you will not hurt yourself, and instead, the Crisis Center." "What are three things you could do that are self-soothing?"
M	**Means**	Assess for suicide or emergency risk; lethality, risk factors, warning signs.	"You say you've taken some pills...what kind and how many?" "You have a gun there; is it loaded?" "You've cut your wrists?"
	Match	Match your intervention to the means.	"I'm seriously worried about you and I'd like to call the paramedics." "What is your number/address?" "Is there anyone there w/ you?"
	Measurable	Make the plan of action measurable, not magical.	"So, you'd like to walk around the block 2 times before you call back." "You'd like to nap until 5:00 am and then re-evaluate." "You'll eat a sandwich after we hang up."
A	**Ambivalence**	Notice for your client that they state they want to die, YET they are asking for help.	"It sure does sound like you've given up all hope, and yet I'm aware that you called me [or us here at the Center] to connect with someone." "Just when it seemed that no-one understood, you reached out to me."
	Assess	Assess, assess, assess.	"Is there anyone there with you?" "Has something happened recently?" "Have you been drinking?" "Have you attempted suicide before?"
	Anticipate	Anticipate what problems you might have with the call and predictors for your client.	**Possible problems:** "Supervisor, I need you!" "My client is difficult to understand. Intoxication is making the assessment difficult to gather." **Possible Predictors:** "Our plan is a good one, but it does not make all the losses go away." "You may feel vulnerable tomorrow, but that is normal"
R	**Remove Means**	Engage the client in removing the means for suicide.	"I'd like for you to put the gun down...would you do that please?" "Would you flush the pills down the toilet?"
	Relationship	Respond to the relationship. When the call gets shaky, rebuild rapport.	"I really care, and I'm feeling worried for you." "Tell me more about what that [hopeless, angry, etc.] feels like." "Even though I don't know you, I sure do care."
	Realistic	Strive for realism. The plan of action should be do-able, within the client's reach.	"So even though you don't have transportation, you think you have a friend who might help you?" "So you think you can make that phone call tomorrow when business hours resume?"
T	**Test**	Test your client's understanding of your agreement, what happens next.	"So just to be clear, you're going to call your friend in the morning...Does that sound like something you could do?"
	Time	Commit to a time frame: Scale back to a time frame he/she can commit.	"Do you think you could keep this promise until tomorrow?" "What about till in the morning?"
	Tomorrow	Clarify what tomorrow's plan might include.	"If you need to check back with us, you'll do it." "So tomorrow you're going to call your counselor/doctor?"

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Since Last Visit**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	Yes ☐ No ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes ☐ No ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	Yes ☐ No ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____
Aborted Attempt or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	Yes ☐ No ☐ Total # of preparatory acts _____
Suicide: Death by suicide occurred since last assessment.	Yes ☐ No ☐
	Most Lethal Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Since Last Visit

1. Wish to be Dead

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.
Have you thought about being dead or what it would be like to be dead?
Have you wished you were dead or wished you could go to sleep and never wake up?
Do you wish you weren't alive anymore?

If yes, describe:

Yes ☐ **No** ☐

2. Non-Specific Active Suicidal Thoughts

General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.
Have you thought about doing something to make yourself not alive anymore?
Have you had any thoughts about killing yourself?

If yes, describe:

Yes ☐ **No** ☐

3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act

Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."*
Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?

If yes, describe:

Yes ☐ **No** ☐

4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan

Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*
When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?
This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.

If yes, describe:

Yes ☐ **No** ☐

5. Active Suicidal Ideation with Specific Plan and Intent

Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.
Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?
What was your plan?
When you made this plan (or worked out these details), was any part of you thinking about actually doing it?

If yes, describe:

Yes ☐ **No** ☐

INTENSITY OF IDEATION

The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).

Most Severe Ideation: _____ _____
Type # (1-5) ***Description of Ideation***

Most Severe

Frequency

How many times have you had these thoughts? ***Write response*** _____

(1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable

____

Step 5: Document

- Risk level and rationale; treatment plan to address/reduce current risk; firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include role for patient/guardian
- Documentation should occur at first assessment and/or triage, whenever there is a change in clinical state, with any major shifts in treatment plan, at any change in the level of care, and before terminating a relationship.

Question-Asking Strategies

- Other people have similar problems sometimes lose hope; have you?
- Are you feeling hopeless about the present or future?
- This must be a hard time for you; what do you think about when you're feeling down?
- With this much stress, have you thought of hurting yourself?
- Have you had thoughts about taking your life?
- When did you have these thoughts and do you have a plan to take your life?
- What would happen to your family or significant others if you did that?
- What has kept you from acting on these thoughts?
- Have you ever had a suicide attempt?

Material has been adapted from SAFE-T pocket card from www.sprc.org

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

A Quick Guide for Clinicians

Step 1: Identify Risk Factors

Note those that can be modified to reduce risk

Step 2: Identify Protective Factors

Note those that can be enhanced

Step 3: Conduct Suicide Inquiry

Suicide thoughts, plans, behaviours, and intent

Step 4: Determine Risk Level/Intervention

Determine risk. Choose appropriate intervention to address and reduce risk

Step 5: Document

Assessment of risk, rationale, intervention, and follow-up

Suicide assessment and documentation should occur at first assessment and/or triage, whenever there is a change in clinical state, with any major shifts in treatment plan, at any change in the level of care, and before terminating a relationship.

Step 1: Identify Risk Factors

- Suicidal behaviour: history of prior suicide attempts or self-directed violence
- Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol and substance abuse, ADHD, PTSD
- Key symptoms: anhedonia, impulsivity, aggression, hopelessness, anxiety, insomnia
- Family History: of suicide, attempts, child maltreatment, or Axis I psychiatric disorders requiring hospitalization
- Stressors: triggering events leading to humiliation, shame, or despair. Ongoing medical illness. Intoxication. Family distress. History of physical or sexual abuse. Social isolation. Loss of primary relationships, culture, or sense of community.
- Access to firearms, pesticides, or other lethal means

Step 2: Identify protective factors

- Family and community support, feelings of connectedness
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes and coping with stress
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation
- Responsibility to children or beloved pets

Step 3: Conduct Suicide Inquiry

- Ideation: frequency, intensity, duration (in the last 48 hours, past month, and worst ever)
  - "What kinds of thoughts have you been having?"
  - "How long have you been having these thoughts? When did they first start?"
- Suicide Plan: timing, location, lethality, access to means, preparatory acts
  - "Do you have a plan of how you would kill yourself?"
  - "Do you have any firearms or other weapons at home?"
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal or self-injurious
  - "In the next 24-48 hours, how likely is it that you will act on your suicide plan?" (Ask the patient to rate the likelihood on a scale of 1 to 10, with 1 being very unlikely and 10 being certain."
  - Explore ambivalence: reasons to die vs. reasons to live.

Step 4: Determine Risk Level/Intervention

- Assessment of risk level is based on clinical judgment, after completing steps 1-3

RISK LEVEL	RISK/PROTECTIVE FACTORS	SUICIDALITY	POSSIBLE INTERVENTIONS
HIGH	Psychiatric disorders with severe symptoms, or acute precipitating event	Potentially lethal suicide attempt or persistent ideation with strong intent or rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions.
MODERATE	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behaviour	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
LOW	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behaviour	Outpatient referral, symptom reduction. Give emergency/crisis numbers.

Commitment to Treatment Statement (CTS) SAMPLE

Important Clinical Notes:

- The CTS does not restrict the patient's rights with respect to the option of suicide; it does not specifically mention that the patient is removing the suicide option, only that the patient is making a commitment to living by engaging in treatment and accessing emergency services if needed. Both are critical to the effectiveness of such agreements early in the treatment process.
- Suicide as an option will eventually have to be addressed in treatment. It is most appropriate to address the question after the therapeutic relationship has been firmly established, the patient has experienced some symptomatic relief, and the patient has developed adequate skills for self-management of crises.
- It is recommended that the CTS always be handwritten and individualized by the clinician; avoid using a standard preprinted form. The CTS should always include a crisis response plan, that is, the specific steps the patient should take during a crisis.

I, _____, agree to make a commitment to the treatment process. I understand that this means that I have agreed to be actively involved in all aspects of treatment including:

(1) attending sessions (or letting my therapist know when I can't make it),

(2) setting goals,

(3) voicing my opinions, thoughts, and feelings honestly and openly with my therapist (whether they are negative or positive, but most importantly my negative feelings),

(4) being actively involved during sessions,

(5) completing homework assignments,

(6) taking my medications as prescribed,

(7) experimenting with new behaviors and new ways of doings things,

(8) and implementing my crisis response plan when needed (see the attached crisis response plan card for details).

I also understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount of energy and effort I make. If I feel like treatment is not working, I agree to discuss it with my therapist and attempt to come to a common understanding as to what the problems are and identify potential solutions. In short, I agree to make a commitment to living.

This agreement will apply for the next three months, at which time it will be reviewed and modified.

Signed: _____ Date: _____
Witness: _____

The Gold Standard for Suicide Care (Donald Meichenbaum)

1. What did they do to establish and maintain a therapeutic alliance with their suicidal patient?

2. What specific assessment strategies and assessment measures (interviews, observational data, self-report measures, measures of current and past risk and protective indicators) did the health care staff employ on an ongoing basis to monitor the patient's suicide risk?

3. How was this information conveyed to the suicidal patient (feedback) and to significant others in the patient's life (family members and to members of the treatment team)?

4. What specific diagnoses (primary and comorbid) were formulated and how did this information impact the treatment plan?

5. What specific steps were taken to reduce the presence of risk factors (psychoeducation of patient and significant others, removal of risk factors, provision of aftercare interventions, provision of a specific safety plan and back-up supports)?

6. What was done explicitly to address treatment adherence to psychotropic medications, address both barriers to treatment and antitherapeutic patient behaviors?

7. What specific psychotherapeutic interventions were provided and evaluated for their efficacy?

8. When the suicidal patient was an inpatient, what explicitly was done to ensure the patient's safety (supervision, safety checks, maintain and communicate risk status to other treatment team members)?

9. Where and when were all of these steps documented?

CASE STUDY

Jordan is a 58-year-old African American lesbian female who is a newly licensed social worker in a clinical mental health clinic in a rural community. Jordan overheard her supervisor making prejudicial comments about one of the supervisor's clients named Toni. Toni is biologically a male but identifies as a female. Jordan, who is an advocate for LGBTQ+ rights, decided to access Toni's mental health record and found that Toni is struggling with depression, anxiety, and suicidal ideation.

Jordan, who has had previous similar issues, found Toni on Facebook. When Jordan sent Toni an invitation to join an advocacy group that Jordan runs in the community. Toni then saw Jordan at the clinic and thanked Jordan for the information. Jordan then provided her personal email address to Toni and said that Toni can "contact her [Jordan] at any time for help."

Toni emailed Jordan late one evening stating she was going to kill herself. When Jordan attempted to call and text Toni did not answer or respond, Jordan left multiple messages. Jordan had not contacted her supervisor due to his earlier prejudicial comments towards Toni. She also did not reach out to any other supervisors at the clinic because Jordan had not revealed her sexual orientation to anyone at the clinic and did not want this information shared with others.

DIRECTIONS:

As a group, use Barnett and Johnson's nine-step ethical decision-making model to work through this case. Be as specific as possible in your responses! Designate: someone to be a notetaker, someone to keep the group on task, and 1-2 people to be spokespersons.

Step 1: Define the situation clearly

Step 2: Determine who will be affected

Step 3: Refer to both underlying ethical principles and the standards of the NASW Code of Ethics

Step 4: Refer to relevant laws/regulations and professional guidelines

Step 5: Reflect honestly on personal feelings and competence

Step 6: Consult with trusted colleagues

Step 7: Formulate alternative courses of action

Step 8: Consider possible outcomes for all parties involved

Step 9: Make a decision and monitor outcome

Use this worksheet to jot down your group's responses in each area.

Define the situation clearly.	
Determine who will be affected.	
Refer to both underlying ethical principles and the standards of the NASW Code of Ethics.	
Refer to relevant laws/regulations and professional guidelines.	
Reflect honestly on personal feelings and competence.	
Consult with trusted colleagues.	
Formulate alternative courses of action.	
Consider possible outcomes for all parties involved.	
Make a decision and monitor outcome.	

Termination Case Study

Sam the social worker, LCSW, has been seeing his client Jessica for eight sessions. Jessica was initially referred for complaints of difficulty managing anger, difficulty with interpersonal relationships and depression.

As the sessions progress, Sam realizes that Jessica has very high suicidal ideation and multiple plans to kill herself, although without apparent intent to carry them out. She has no history of attempts, but the seriousness and frequency of Jessica's suicidal threats have been increasing over time. During sessions, Jessica refuses to focus on anything but her suicidal thoughts and when Sam begins to suggest tactics for coping, Jessica erupts in tears and has outbursts. On two occasions, Jessica stormed out of the session early, overturning various pieces of furniture on her way out.

Sam typically sees clients with difficulties that are more easily resolved by cognitive behavioral approaches. Because he feels that Jessica needs a more intense level of care than what he offers, Sam feels incompetent to manage her case and to be an effective therapist. He has expressed this concern to Jessica directly and has told her he thinks she would be better suited with another clinician. At this time, he had already begun to make what he considered more appropriate referrals.

When Jessica hears this, she initially becomes more compliant and tearfully proclaims that Sam is a lifesaver and refuses to work with someone else. However, after a session or two, Jessica reverts to her old behavior, reinforcing Sam's feelings of incompetence and adding to his confusion regarding what he should do.

Please write your responses to the questions below.

What ethical standards are in conflict in this scenario?

Is termination justified in this case? Why or why not?

What should the social worker's next steps be?