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Decreasing Medical Errors and Minimizing Clinical Risks

Introduction

Understanding clinical risk management in behavioral healthcare is essential for building safer health systems and improving client safety. While medical and behavioral health errors are inevitable, they can have disastrous effects on clients, clinicians, and institutions. Building a safe healthcare system means designing care processes to ensure all clients are safe and professionals have mechanisms to address human errors. Behavioral health professionals can increase their awareness on the causes and seriousness of clinical errors, how these risks can be minimized, and how reporting systems can enhance safety for clients, clinicians, and organizations.

Medical & Behavioral Health Error Definitions

What are medical errors?

Medical errors are common in the United States, leading to 100,000-200,000 deaths per year (White, 2018). According to The Institute of Medicine, a medical error is "The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim."

There are two categories of medical errors:

1. Errors of omission happen as a result of actions not taken. Examples are failure to complete a self-harm assessment, failure to provide informed consent, or failure to acquire a release of information.
2. Errors of the commission happen as a result of the wrong action taken. Examples include administering medication to a patient with a known allergy or not making a mandated report of child abuse due to concern for the family (Rodziewicz et al., 2022).

Rodziewicz et al.(2022) define the following types of medical errors:

Active Error

- Active errors are made by providers on the front line, such as clinicians and nurses. Examples of active errors include operating on the wrong eye or amputating the wrong leg.

Adverse Event

An adverse event is most often due to an error in medical treatment rather than a patient's underlying medical condition. Adverse events are *preventable* when there has been a failure to follow expected standards of practice either at an individual level or system level.

- Only adverse outcomes that are deemed preventable are labeled as medical errors.
- Adverse events include unintended injury, physical disability, or extended hospitalization due to medical patient management.

Latent Error

- Latent errors include errors in system design, process design, incorrect installation of equipment or failure to maintain equipment, or ineffective organizational structure.
- Latent errors are "accidents waiting to happen." They may be present for a long time and go unnoticed without consequence. An example could be a hospital that uses several types of chest drainage systems, all requiring different connections and setups. However, not all nurses are trained in the setup of each different system, creating the potential for error.

Medical Error

- The failure to complete the intended plan of action or implementing the wrong plan to achieve an aim.
- Failure to follow the process of care, which may result in harm.
- The act of omission or commission when executing a procedure that leads to an unintentional consequence.

Negligence

- Failure to meet the reasonably expected standard of care for the profession regarding the care of a patient with a particular diagnosis. For example, failure to

complete a comprehensive bio-psycho-social assessment prior to diagnosis and treatment planning.

Negligent Adverse Events

- A subcategory of *preventable*, adverse events where the injury was caused by substandard medical care.

Near Miss

- A potential adverse event that could have caused harm but did not due to chance or intervention by someone or something.
- Near misses are opportunities to develop preventive strategies and actions. They should receive the same level of investigation as an adverse event.

Never Event

- Never events are errors that should not ever have happened. An example of a never event is wrong-site surgery.

Noxious Episode

- Noxious episodes include events, complications, and mishaps resulting from acceptable diagnostic or therapeutic measures that follow instituted protocols but are inappropriate for the situation. For example, emergency room patients must complete a mental health screening prior to psychiatric care, but the patient presents in extreme suicidal distress and is provided standard care instead of fast-tracking to psychiatric care. Noxious episodes have the potential to cause injury or death.

Patient Safety

- The process of avoiding, improving, and preventing adverse outcomes or injuries that may happen as a result of seeking healthcare.

Potentially Compensable Event

- An error due to medical care that caused injury or prolonged hospitalization that could potentially lead to malpractice claims.

Root Cause

A failure that, if corrected, will eliminate the undesirable consequence.

Common root causes include:

- Failure to seek advice from colleagues, misapplication of expertise, failure to create a plan, lack of consideration for differential diagnosis, and providing care on autopilot.
- Communication issues, lack of understanding of the hierarchy, lack of leadership, no knowledge of whom to report the problem to, failure to disclose the problem, or having a disjointed system with no problem-solving ability.
- Inadequate education, experience, training, and orientation.
- Deficiencies in methods of identifying patients, incomplete assessment on admission, failing to obtain consent, and failure to provide education to patients.
- Inadequate policies to guide healthcare workers.
- Lack of consistency in procedures.
- Inadequate staffing and/or poor supervision.
- Technical failures associated with medical equipment.
- No audits in the system.
- No one is capable of taking responsibility for problems or ways to make system changes.

Sentinel Event

A sentinel event is defined by the Joint Commission as "any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof...The phrase 'or the risk thereof' includes any process variation for which a recurrence would

carry a significant chance of a serious adverse outcome." Once sentinel events are discovered, they frequently indicate the need for an immediate investigation, the discovery of the cause, and a response. Sentinel events signal the need for investigation and response. Examples of sentinel events include:

- The unauthorized departure of a patient from a staffed-around-the-clock care setting resulting in death or harm
- Procedures on the wrong patient
- Rape, assault, or homicide of any patient receiving care
- The suicide of any patient receiving care in a staffed-around-the-clock care setting within 72 hours of discharge

Approximately 10% of sentinel events are reported in psychiatric hospitals, while the majority occur in acute care hospitals.

Joint Commission Patient Safety Goals

The Joint Commission is an organization that accredits and oversees healthcare organizations and programs. The Joint Commission's mission is to improve health care for the public through collaboration with healthcare organizations. They accomplish this by evaluating healthcare organizations and encouraging them to continuously improve in delivering high-quality, safe, and effective care to their consumers. Each year the Joint Commission identifies areas of attention for improved patient safety. The 2023 National Patient Safety Goals for the Behavioral Health Care and Human Services program are as follows (Joint Commission, 2022).

Identify individuals served correctly

Goal: Treatments this goal covers include high-risk interventions and certain high-risk medications (for example, methadone). Visual recognition as an identifier is acceptable in some situations. Such settings include those that serve an individual on a regular basis (for example, therapy) or serve a small number of people (for example, a group home). These are settings where the individual stays for an extended period of time, the staff and populations served are stable, and patients are well-known to the staff.

Rationale: Errors in misidentifying the individual served can occur at any stage of diagnosis or treatment. This goal has two objectives: first, to reliably identify the individual as the person for whom the service or treatment is intended, and second, to match the service or treatment to that individual. Individuals' names, assigned identification numbers, phone numbers, and other person-specific identifiers are all acceptable identifiers.

Use medicines safely

Goal: Medication reconciliation is an important safety issue due to the large number of people receiving care, treatment, or services who take multiple medications and the complexity of managing those medications. A clinician performs medication reconciliation by comparing the medications that the individual served should be using (and is actually using) to the new medications that have been ordered for the individual and resolving any discrepancies. In settings where medications are not routinely prescribed or administered, it is up to the organization to determine what medication information is required based on the services it provides. Even when medications are not used, it is important for clinicians to know what medications the individual is taking when planning care, treatment, or services.

Rationale: There is evidence that medication disparities can have an impact on outcomes. Medication reconciliation is a process that compares medications that an individual is taking (or should be taking) with newly ordered medications in order to identify and resolve discrepancies. The comparison takes into account duplications, omissions, interactions, and the need to keep taking current medications. Among the information used by clinicians to reconcile medications are the medication name, dose, frequency, route, and purpose. Organizations should determine what information is required to reconcile current and newly ordered medications and to safely prescribe medications in the future.

Prevent infection

Goal: Use the hand-cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Rationale: According to the Centers for Disease Control and Prevention, millions of people become infected while receiving care, treatment, or services in a healthcare

setting each year. As a result, healthcare-associated infections are a major safety concern for all types of healthcare organizations. One of the most important ways to address healthcare-associated infections is by improving the hand hygiene of healthcare staff.

Identify individuals served safety risks

Goal: Reduce the risk for suicide

Rationale: The suicide of an individual served while in a 24/7 staffed care setting is a commonly reported type of sentinel event. Identifying people at risk for suicide while under the care of or immediately following discharge from a healthcare organization is an important step in protecting these at-risk individuals (Joint Commission, 2022).

Consequences

Every year, approximately 400,000 hospitalized patients suffer some form of preventable harm.

- According to the study, medical errors cost between $4 billion and $20 billion per year.
- Every year, approximately 100,000 people die as a result of medical errors in hospitals and clinics.
- Surgical, diagnostic, medication, device, and equipment errors, system failures, infections, falls, and healthcare technology are all examples of medical errors.
- Common errors in outpatient settings are missed diagnoses and medication-related injuries.
- The majority of malpractice claims in hospitals are for surgical errors, whereas the majority of claims for outpatient care are for missed or delayed diagnoses.
- Outpatient care accounts for slightly more than half of all paid malpractice claims.
- Hospitals often reduce nursing staff in an attempt to decrease overhead; staffing of RNs below target levels is associated with increased mortality (Rodziewicz et al., 2022).

Solutions

When institutional efforts result in the implementation of action plans that reduce medical errors, patient safety, mortality, and morbidity rates will decrease. The most effective mechanism for improving patient safety is implementing structured initiatives focused on teamwork, education, and training. Accepting the contributions of team members, reducing barriers to reporting errors, and promoting a work environment where all individuals work together will significantly improve patient and staff safety.

Errors and Risks in Mental Health

While much of the research and attention is given to medical errors in physical health situations, errors can occur in mental health inpatient and outpatient facilities. Most behavioral health associations have an aspect of "do no harm" in their code of ethics. For example, the American Psychological Association addresses "Avoiding Harm" with clients, students, supervisees, and research participants (APA, 2017). The National Association for Social Work's Code of Ethics addresses social workers' responsibilities not only to their clients but to their colleagues and society (NASW, 2021). The American Association of Marriage and Family Therapy's Code of Ethics states therapists have an ethical responsibility to their clients and supervisees (AAMFT, 2015).

Areas in behavioral health that have been identified as having the most risk are:

Patient Suicide

Patient suicide can occur in any medical discipline, but the odds are significantly higher in psychiatry. One estimate is that as high as 50% of psychiatrists will experience the suicide death of a patient. The goal of many in mental health care is for there to be zero suicides; this is an unrealistic expectation and exacerbates the feelings of guilt, fear, and blame experienced by professionals who experience the death of a patient by suicide. Due to the high likelihood a clinician will experience a patient's death by suicide, it is important that while reviews for quality improvement are necessary, they should not be undertaken as a way to assign blame. The professionals involved will experience their own sadness, shame, and other emotions regarding the loss of a patient, and procedures should be in place to support all impacted staff members.

Most important is assessing suicide risk, and that staff working with suicidal patients are properly trained in assessment. Patients should:

- Be given the expected standard of care, which is defined as the skill and learning that is ordinarily possessed and exercised by members of that profession in good standing,
- Be assessed for suicide risk with an evidence-based screening tool such as PHQ-9, ASARI - Assessment Of Suicide And Risk Inventory or the C-SSRS - Columbia-Suicide Severity Rating Scale or a similar evidence-based screening tool used by the organization (See Appendix A for C-SSRS),
- Have an appropriate treatment plan developed to meet their risk factors,
- Have all their care clearly documented using the organization's official health records documentation system.

The above list is best practices for working with patients with suicide risk. It also protects mental health professionals against malpractice or negligence lawsuits. Should professionals become involved in a lawsuit, they should be very careful with whom they speak. While many organizations have a peer review protocol for incidents, the provider should only participate in these reviews with an attorney present when there is potential for a lawsuit. They should limit any discussion with colleagues, as they could be called as witnesses in the lawsuit. Clinicians should only discuss their case with their attorney and the claims manager for their malpractice insurance. The exceptions to this include the clinicians' own therapist or peer review participants if they practice in a state that provides protections for information shared in peer or incident reviews. (Brauser, 2020).

Risk Management

As suicide is one of the leading causes of liability against a psychiatrist treating adult patients, and at least half of mental health providers will experience the death of a client by suicide, it is critical that all possible steps are taken to mitigate risk, both for the death of one's client and a possible malpractice lawsuit.

Once the provider has completed a risk assessment on a client, all necessary steps should be taken to prevent the client from committing suicide. Symptoms of mental illness should always be addressed. While this may be in an outpatient setting, if a higher level of care is needed, it will be necessary to make the necessary referrals, including hospitalization, partial hospitalization, and crisis services. If the client has an

active suicide plan and refuses to seek treatment, all states have involuntary hospitalization processes so the person can stay safe and get the medical treatment required.

In addition to assessing the level of care the person requires, it is critical to treat symptoms with the proper combination of medication and psychotherapy to meet the individual's needs. Substance use should be assessed as it can contribute to suicidal ideations. Safety planning with the client is a crucial aspect of treatment. Part of safety planning includes means restriction, where the client, clinician, and possibly support persons remove potential means for suicide from the household (removing or locking up firearms and medications, removing or restricting access to sharp objects).

Assessment, treatment plans, safety plans, case notes, and justifications for decisions should be documented for all clients but carries particular weight with clients who are struggling with suicidal ideation (Pinals, 2019).

Diagnosis Errors

According to the Joint Commission, diagnostic errors result in death or injury to 40,000 to 80,000 patients per year. Diagnostic errors, including diagnoses, delay in diagnosis, or incorrect diagnosis, are most common in primary care solo practice due to workload and the inability to cross-reference easily with colleagues (Joint Commission, 2022).

This frequently leads to the following failures; failure to develop a complete differential diagnosis, failure to pursue a differential diagnosis, failure to order appropriate diagnostic tests, failure to address an abnormal test result, and failure to consider all information available.

Patients who have comorbid conditions that distract practitioners from considering the entire differential are at a high risk of diagnostic error. Professionals may make mistakes by focusing on pre-existing conditions rather than ruling out potentially new organic problems. Patients who have poor hygiene are more vulnerable because practitioners may spend less time with them. When patients and caregivers have language barriers or communicate through interpreters, communication errors can occur. Patients who do not follow instructions or follow-up are also at risk of inducing errors (Rodziewicz et al., 2022).

Cognitive Bias & Diagnosis Error

According to some research, 70% of medical errors result from diagnostic mistakes. Cognitive biases' potential to cause errors in clinical thinking is another facet of diagnostic errors. Cognitive bias awareness training and debiasing strategies may be developed to reduce diagnostic errors and patient harm by recognizing how providers make clinical judgments and investigating how errors resulting from cognitive biases happen. A diagnostic error is a failure to accurately and promptly explain the patient's health problem(s) accurately or communicate that explanation to the patient (Royce et al., 2019).

Clinical reasoning is the process of using cognitive abilities, information, and experience to diagnose and treat patients. Because it is challenging to assess, it is challenging to spot cognitive mistakes. Clinical reasoning frequently happens quickly, is rarely documented or explained, and occasionally isn't even immediately clear to the clinician.

Cognitive biases, or predispositions to respond to data based on prior experience or current conditions' exigencies, can contribute to diagnostic errors. The majority of diagnostic error malpractice cases are not due to ignorance but to a failure to consider the correct diagnosis (64% of closed malpractice claims are due solely to diagnostic error, with 79% of those cases including a "failure of judgment."). Other research has found that cognitive bias errors play a role in more than 50% of identified cases of diagnostic error in ambulatory clinics and up to 83% of cases involving physician-reported diagnostic errors. Understanding how errors caused by cognitive biases occur allows for the development of strategies to avoid mistakes and patient harm. (Royce et al., 2019).

The Effects of a Misdiagnosis

Confusion: A misdiagnosis can lead to clients being confused and potentially distraught when the course of treatment is unsuccessful. They may develop feelings of guilt and shame and view their lack of progress as a personal failing.

Incorrect Medication: Clients may begin medications that were prescribed for a condition they don't actually have, which can be dangerous. It also exposes the person to all the potential side effects of medication without receiving any benefits. This could lead to more anxiety and distress while also not addressing the real issues.

Worsening Condition: A misdiagnosed or never diagnosed mental health condition is likely to cause the client's symptoms to worsen. One example is if a client is prescribed an SSRI, which can take several weeks to months to reach therapeutic levels. The client may be told to wait and be patient to give the medications time to take effect, all the while the individual's symptoms are worsening due to misdiagnosis (Hillside, 2019).

Risk Management for Diagnostic Errors

- Avoid first impression diagnosis.
- Complete a full bio-psycho-social assessment, gathering as much client history as possible. Clinicians are more likely to misdiagnose with insufficient information.
- Give consideration that the client may have more than one diagnosis.
- Document a complete differential diagnosis and evaluation.
- Refer for specialist evaluation for patients with possible life-threatening conditions.
- Obtain appropriate consultation.
- Ensure that all handoffs are handled in such a way that the patient is properly cared for. The handoff should include a clear delegation of follow-up on all test results, as well as a proposed plan of action to address the client's symptoms. (Rodziewicz et al., 2022; Hillside, 2019).

Medication Errors

Prescribing medication for the treatment of mental illness is a common treatment approach. However, there is potential for medication errors for numerous reasons, including psychotropic polypharmacy, unlicensed psychotropic prescribing, use of high-risk medications, and known allergies. While medication errors can happen in inpatient and outpatient settings, they are more likely to happen in mental health hospitals. One study found that prescribing errors and medication administration errors were common in mental health hospitals and that preventable medication-related adverse events often harmed patients. The most common errors found in the study were related to the wrong drug, the wrong patient, or the wrong dose of medication. In hospitals, medicine administration regularly occurs in physically and cognitively demanding circumstances

that could compromise the safety of medicine's administration processes (Keers et al., 2018).

Themes found when evaluating an increased risk for medication administration errors included:

- A mix of low staffing and inadequate skills
- A disruptive and distracting work environment
- Individual stress and task management
- Communication deficiencies (Keers et al., 2018).

Preventing Medication Errors

Poor communication or misunderstandings about medication use cause numerous medication errors. Providers should reconcile their medication records with their patients and inform patients about appropriate medication use. They can also encourage patients to be active members of the healthcare team by maintaining their own lists of medications and allergies and ensuring that they share this information with their providers (Wu et al., 2019).

Mandatory Reporting

Mandatory reporting laws establish a legally enforceable duty for those who have contact with vulnerable populations to report to state and local authorities when mistreatment or abuse of those populations is suspected or confirmed. While these laws, and the populations they cover, vary by state, they generally include children, the disabled, and the elderly. These laws typically cover neglect, as well as physical, sexual, emotional, and financial abuse. While those individuals mandated to report also vary by state, they generally include childcare providers, clergy, coaches, counselors, healthcare providers, law enforcement professionals, principals, and teachers. Some states also assign this reportable duty to abuse between intimate partners. (Thomas & Reeves, 2022).

Mandated reporters are required by law to report any reasonable suspicion of abuse or maltreatment when they are in their official professional role. When they are not in the setting where they practice their professional duties, they are no longer mandated to report abuse. An example of this would be a counselor witnessing an adult slapping a

child multiple times in the grocery store while the counselor was shopping. Any member of the public can report suspected child abuse, and the counselor may choose to based on what is witnessed. However, since the individual was not working in the role as a counselor when the maltreatment was observed, there is no legal obligation to report the incident. (OCFS-NYS, 2021).

Reasonable cause to suspect child abuse or maltreatment means that, based on observations, training, and experience, the professional suspects the parent or other person legally responsible for a child is harming the child or placing the child in imminent danger of harm. A person legally responsible for a child includes parents, guardians, caretakers, or another person over the age of 18 who is responsible for the care of the child. An example of a suspicion might be distrusting an explanation for an injury (OCFS-NYS, 2021; Thomas & Reeves, 2022).

Abuse involves the most serious injuries and/or risk of serious injuries to a child by a caregiver. An abused child is one whose parent or legal guardian causes serious physical injury to the child, creates a substantial risk of serious physical injury, or commits a sex offense against the child. Abuse also includes situations where a parent or caregiver knowingly allows someone else to inflict such harm on a child. Maltreatment means that a child's physical, mental, or emotional condition has been impaired or placed in imminent danger of impairment by the failure of the child's parent or legal guardian to exercise a minimum degree of care. Examples include failure to provide sufficient food, clothing, shelter, education, or medical care. Excessive corporal punishment or exposure to drugs or alcohol that places the child in potential danger are also examples of maltreatment (OCFS-NYS, 2021).

Children

Child abuse is a significant cause of morbidity and mortality. The mistreatment of children is a serious issue of public health concern, and it affects 1 in 8 children before the age of 18 years. Homicide is one of the top five causes of death for children of every age category. The effects of abuse and neglect do not stop at age 18; physical and mental health problems due to abuse as a child can extend far into adulthood. Numerous studies have shown a correlation between adults who experienced abuse as children and the development of a host of adult morbidities, ranging from cardiovascular disease to depression (Thomas & Reeves, 2022).

Elderly

Abuse and mistreatment are common among the elderly, with research showing the likelihood of 10% of the entire population aged 60 years and above experiencing some type of abuse or maltreatment. The elderly population is more susceptible to abuse due to circumstances such as poor physical health, functional impairment, and residence in nursing homes. Elderly patients residing in nursing homes are at risk of abuse not only from staff but also from other residents. Elderly abuse is historically underreported, highlighting the importance for providers to assess for abuse and maltreatment with clients over the age of 60 (Thomas & Reeves, 2022).

Intimate Partners

Intimate partner abuse is sometimes overlooked as an area of abuse compared to other vulnerable situations. Intimate partner abuse is experienced by close to 1 in 3 women during their lifetime. While women are the most frequent victims of intimate partner abuse, the issue also affects men, with one study showing men comprise 17% of the victims of intimate partner violence. Like other groups, however, victims are often at significant risk for further, more severe injury if there is no intervention (Thomas & Reeves, 2022).

Providers have an important ethical and legal role in identifying and reporting abuse in children and other vulnerable populations to the appropriate state agencies. In the clinical setting, the most common form of maltreatment reported by professionals is neglect, which can encompass medical, nutritional, physical, or emotional neglect. These issues profoundly affect the health and well-being of a significant portion of the population. It is estimated that 37% of children in the United States have some involvement with Child Protective Services by the age of 18 (Thomas & Reeves, 2022).

Case Study

A mental health counselor is seeing a 17 year old female who discloses her uncle sexually abused her. The client states this happened when she was ten years old and lived in another state. The uncle continues to live in the other state, while the client and her family reside in their new location. The mental health counselor believes, in good faith, that because the abuse happened in another state, the abuser lives in another state, and that the abuse occurred seven years ago, a report is not legally necessary. The counselor believes that criminal prosecution of the uncle is not possible because of the

statute of limitations. The counselor tells the client she can report the abuse herself and that the report should be made in the state where the uncle lives. The client is very clear she does not want a report to be made, she has no relationship with her uncle and never sees him, and she plans to keep it that way.

Discussion

The counselor failed to report child abuse, and that is a violation of the law. The client is 17 years old and, therefore, still legally defined as a child according to child abuse reporting laws. Had the client been 18 years old when she shared this information with the mental health counselor, the situation would have been different as it would have been an adult disclosing abuse that happened when she was a child. The timing of the statute of limitations is not relevant to whether a report is required. In this case, the perpetrator may or may not be prosecuted, but that is not the only purpose of mandated reporting. The primary goal of child abuse reporting laws is to protect children from abuse and neglect.

Although the abuse happened out of state and the uncle resides out of state, the counselor should make the report to the state-mandated reporter hotline where the client currently lives. From there, the hotline will forward the information to the state where the uncle resides. Some states may give the counselor the mandated reporter hotline for the uncle's residential state and have the counselor make the report firsthand.

Whether the lack of making a report is a crime depends on what state laws may or may not have been violated. Furthermore, ascertaining if a crime was committed could make a significant difference in the outcome. If it is determined to be a crime, the counselor’s license may be suspended or revoked by the state licensing board. In extreme cases, there could be fines or imprisonment, and malpractice insurance may not cover any claims involving criminal acts.

In the example above, while the failure to make a report was clear negligence on the counselor's part, it occurred because of the belief that a report was not required, and there was no malintent. This is different from a provider who is aware of abuse or maltreatment and chooses not to make a report. Sometimes providers are reluctant to

make a report for fear it will harm the child further or damage the family. Practitioners should not substitute their judgment for what is required by law (Leslie, 2019).

Boundary Crossings and Boundary Violations

Boundary violations and boundary crossings, while different, should be considered while assessing conflicts of interest. Boundary violations are unethical and harmful to clients. They happen when therapists are involved in exploitative relationships, such as sexual contact with a client or an exploitative business transaction.

Boundary crossings are not unethical and can be therapeutically helpful. Examples include

- grocery shopping with a client with agoraphobia,
- having lunch with a client struggling with an eating disorder,
- making a home visit to a client who lacks transportation,
- going for a walk with a depressed client,
- accompanying clients to a medical appointment that they would not attend on their own.

Boundary crossings should only occur based on the client's needs and what the situation requires. When a boundary crossing is instigated, the treatment plan should include and clearly state the rationale. Boundary crossings are unavoidable, normal, and even expected in rural, military, university, and interdependent communities such as the deaf, ethnic, or LGBT groups. Particular cultures have varying expectations, customs, and values and judge the appropriateness of boundary crossings differently. Communally-oriented cultures are more likely to accept what clinicians perceive to be boundary crossings and may frown upon the strict implementation of boundaries in therapy (Zur, 2023).

Not all boundary crossings constitute dual relationships or inappropriate interactions. For example, making a home visit, going on a walk, grocery shopping with a client, and many other 'out-of-office' experiences are boundary crossings, but they are not considered dual relationships. Neither is exchanging gifts, hugging, or sharing a meal. However, all dual relationships, including bartering, attending the same church, and playing in the same recreational league, constitute boundary crossings (Zur, 2023).

Boundary dilemmas should be individually processed. Each boundary dilemma requires an analysis of six factors: the potential harm to the patient and the patient-physician relationship, the potential benefit to the patient and the patient-physician relationship, the presence or absence of coercive and exploitative elements in the boundary crossing, the professional's motives and intentions, the professional's aspiration to professional ideals of care, and the context, including the cultural considerations, of the boundary crossing. Through such an analysis, clinicians can consider whether a boundary crossing would be encouraged, permitted, or prohibited, depending on the totality of these factors (Friedman & Martinez, 2019).

For example, if a physician decides to have an intimate relationship with a patient, the potential for harm and the unlikely benefit to the patient and patient-physician relationship are obvious. The potential for coercion and misuse of personal information obtained in the patient-physician relationship would be high. The physician's motivation and intention are unlikely to represent altruistic values and are certainly counter to placing the patient's interests above those of the physician. It is doubtful that the physician's aspiration to some ideal care could be the justification for such behavior.

This analysis would lead to the conclusion that such a boundary crossing is clearly a boundary violation and should be prohibited. At the other end of the spectrum, simple boundary crossings, such as offering a patient food or refreshment during treatment or even interacting with a patient in a socially appropriate setting, might be permitted and encouraged depending on context. Still, the inevitable social interaction may raise issues for the patient and the therapist and create gratification and curiosity; this may be grist for the mill in treatment. Not only are clinician-client sexual relations clear boundary violations, which could be considered a medical error or clinical risk, but they are also unethical in all behavioral health professions and considered criminal behavior by many state laws (Friedman & Martinez, 2019).

Risk Management

Boundaries should be set clearly at the start of therapy, and expectations reviewed with clients as part of the informed consent. With some clients, boundaries will need to be re-reviewed or re-established.

When determining if a situation justifies a boundary crossing, clinicians should consider the following:

- What would be the “worst case” scenario?

- Ask themselves, "what do I gain?"
- Might this be an “appearance” of a conflict of interest?
- Remember, boards are quite conservative about boundaries.
- Documentation, consultation, and informed consent are crucial in decision-making and if there is a later complaint (Taube & Younggren, 2022).

Social Media

When a physician or clinician uses social media and patients seek out the physician online, there is a risk of blurred boundaries between the personal image and the professional. These blurred boundaries can affect how the behavioral health professional is viewed by the community. Creating distinct personal versus professional social media personas for online social media use and carefully reviewing what personal information is in the public domain on social media can help prevent a blurring of personal and professional boundaries. Venting or complaining about patients in online forums or on social media is unprofessional. One should also be aware that online postings are permanent. If providers choose to use social media, they should avoid interactions with clients and have strict privacy settings on their accounts. When using social media or dating websites, providers may inadvertently come in contact with patients and engage in undue familiarity (Friedman & Martinez, 2019).

Ongoing concerns exist because ethical standards surrounding technology seem to be constantly lagging behind the fast-paced progress of today's technology. It would be easy for most to come up with a list of the benefits and dangers of social media, both personally and professionally. The challenge for mental health professionals is to use the benefits and opportunities that social media allows for without causing harm and to reflect critically on their incorporation into everyday practice. For example, many practitioners utilize social media to publicize professional services. Social media enhances providers' capacity for career building by enabling them to promote themselves as employable and professional. This is also an important consideration for job-seekers, as many potential employers check applicants' personal websites and social media postings and use social networking sites for recruitment.

Employees should be aware that it is possible to lose one's job due to social media misuse or privacy breaches. Practitioners must consider their online content's impact on service users and the risks this may pose for them individually, professionally, and to

their clients. Lack of clarity on what is allowed and what is not in online spaces gives rise to "ethical grey zones" for clinicians. There are frequently blurred boundaries between public and private spaces online. Additional consideration needs to be given to social media sites that require users to agree to terms and conditions that allow for surveillance, target marketing, and data mining. Many apps retaining users' details, conversations, and material they have shared privately create a wide-ranging audience for material posted on the internet (Boddy & Dominelli, 2017).

Using social media or search engines to research patients may help the clinician understand the patient's behaviors and online presence. However, doing so may decrease the patient's trust in the practitioner-client relationship. While online research can sometimes provide valuable insight into a client's mental status and belief systems or symptoms, what the client posts online may constitute impression management rather than the objective truth (Friedman & Martinez, 2019).

Depending on one's professional standards, a client search on social media may be viewed as unethical, as in the NASW Code of Ethics.

The NASW Code of Ethics (2021) includes the following considerations and standards regarding social media usage:

- Social workers should avoid communication with clients using technology (this includes telephone, text messages, email, social networking sites, online chat, and video) for personal or non-work-related purposes. (These are not secure methods of communication and may violate privacy and confidentiality, and HIPAA regulations).
- Social workers should be aware that posting personal information on professional websites or other online locations may cause boundary confusion, inappropriate dual relationships, or harm to clients.
- Social workers should be aware that personal affiliations may raise the potential that a client may discover the social worker's presence online, including through websites, social media, and other forms of technology. Social workers should be aware that involvement in online communication with groups based on language, race, ethnicity, gender identity or expression, sexual orientation, mental or physical ability, immigration status, religion, and other personal affiliations may impact their ability to work effectively with certain clients.

- Social workers should avoid accepting requests from or engaging in personal relationships with clients on social networking sites or other electronic media to prevent boundary confusion, inappropriate dual relationships, or harm to clients.

Problematic behaviors or postings on social media that have led to complaints and investigations of providers include

- Inappropriate or nonprofessional interactions with patients (sexual communication)
- Misrepresentation of credentials online
- Inappropriate venting (mocking patients or others in healthcare)
- Self-presentation (irresponsible behavior such as drunk pictures, participating in illegal activities, sexual postings, religious or political postings, and photos with weapons)
- Friending patients on social media
- Online voyeurism of patients
- Providing clinical advice without an established relationship
- Failure to maintain confidentiality or privacy
- Lack of privacy settings on social media
- Bullying colleagues
- Negative postings about employers (Friedman & Martinez, 2019)

Social Media Risk Management

Healthcare professionals and students can use caution with social media to mitigate risks. The following tips can help keep your social media content in the clear:

- Always maintain patient privacy and confidentiality.
- Do not post patient images, identify patients by name, or post information that could identify patients.
- Do not refer to patients in a disparaging manner, even if patients are not identified.

- Do not take photos or videos of clients on personal cell phones.
- Use caution when connecting with patients or former patients via social media.
- Minimize the use of social media and avoid sharing too much personal information.
- Remove inappropriate photos, negative comments about colleagues or employers, and evidence of drug and alcohol use.
- Be aware of and comply with employer policies regarding the use of employer-owned electronic devices and the use of personal devices at work.
- Promptly report any identified breach of confidentiality or privacy (HPSO, 2023).

Case Study

A social worker started a social media page for her private practice business. Her practice specialty is LGBTQ issues. Because of her expertise, she has begun being asked to give local presentations. Her latest social media post was of a presentation she had given earlier in the week. Her goal for the post was to educate and inform the public and promote her speaking services, an area of her business that she is expanding. Unfortunately, her video drew numerous comments that showed a lack of understanding of LGBTQ issues. She replied to each comment correcting the misinformation. The comments quickly turned ugly, with commenters making derogatory comments and using offensive language. The social worker is unsure how to address this or prevent it from deteriorating further.

Discussion

When using social media for business, behavioral health providers should have a clear plan on how they will address negative comments before they occur, because they are inevitable. They may want to post the policy they choose to follow as part of the "About" section of their social media profile.

Engaging with negative commenters is discouraged as there is a chance it will spiral further out of control, and the provider is unlikely to change the negative commenter's mind. There is also potential on social media for individuals to lose their cool and reply in a manner that is unprofessional. In these types of situations, providers could choose

to delete the negative comments, turn off commenting for that specific post or for their whole page (permanently or temporarily), or delete the post completely.

Moving forward, providers could create a social media policy that covers what they post, if they allow comments and if they reply to comments, and how to address negative comments. They should also regularly review privacy settings, as many platforms update these on a rolling basis. Providers should also review their professional codes of ethics and state licensing board regulations to verify what the social media policy is for those organizations and verify they are compliant.

Email & Text Messages

Email or text communication with patients allows providers to be more accessible and to answer simple questions without waiting for an appointment. However, risks include replacing valuable face-to-face appointments, misunderstandings of communications (resulting from the lack of tone of voice or body language and nonverbal cues), and the potential for problems with confidentiality. Providers should establish guidelines about what issues may be communicated digitally and only use emails or texts with clients who are attending follow-up appointments. Client consent should be obtained, and communications should be copied into the client's medical record. Another risk is that a provider may unintentionally misdirect an email, leading to a breach of confidentiality (Friedman & Martinez, 2019).

Unsolicited emails pose another ethical situation, and the clinician may incur liability if care is not taken in deciding whether to respond. Finding a provider's email address through an internet search is generally rather easy to do. If a non-client emails a provider about a mental health issue, what is the most appropriate response for the provider to take? While there may seem no harm in replying, if the provider responds to specific issues, this could be considered the initiation of a provider-client relationship. However, not replying to a person who is writing to a provider about mental health concerns may seem callous. Unsolicited emails from unknown individuals are not necessarily reliable or objective sources of information (you don't know who is really emailing you or if the individual is located in a region where you are licensed to practice). There is also a risk of creating a duty of care if one replies, despite the inability to adequately assess the individual seeking help.

Potential solutions for providers receiving unsolicited emails include not opening unsolicited emails from unknown senders or sending a standardized autoreply. Clinicians

should use caution when sending a personal reply to an unsolicited email. An appropriate reply may be a generic statement reminding the person of the lack of a provider-client relationship and encouraging the person to seek help. Again, replying in a specific way and giving certain advice to the person emailing about a situation might appear to establish such a provider-client relationship, even if one is merely trying to be helpful. Also, the e-mailer may misinterpret the return email as a source of medical information and not seek actual help in person. If clinicians do reply, it is prudent to politely state that they are unable to help. Specifically, they can respond that it is inappropriate to offer advice due to the absence of a provider-client relationship and lack of information, and can encourage the individual to seek help locally (Friedman & Martinez, 2019).

Risk Management

Questions to consider regarding ethical decision making around online interactions include:

- Are professional boundaries being blurred?
- Do online behaviors involve strictly professional activities? Are these interactions documented in the client's record?
- Are online behaviors secret or romantic? Have you discussed them in peer review or in supervision?
- Are any boundaries being crossed by these behaviors?
- Are the online interactions for the benefit of the client? Is there anything about the interaction that is self-serving, exploitative, financial, or romantic?
- Is the volume of emails the client sends appropriate to the clinical concern?
- Have the emails been discussed in the session with the client?
- Would the same thing be said to the client in person as is being communicated by email?
- Is "Googling" the client for the client's benefit or out of curiosity or voyeurism?
- Has the clinician paused and reflected before posting on social media?

- Would what is being posted be appropriate behavior in a clinical setting? (Friedman & Martinez, 2019).

Telemental Health

Telemental health is the use of telecommunication technologies to provide mental health services.

A study investigating the use of cyber communications (email, texting, and social network sites) in the social worker-client relationship concluded that "cyber communication has dramatically impacted traditional social work practice in clinical, practical, ethical, and legal ways" and "revolutionized the communication of practitioners and clients, even those engaged in traditional face-to-face therapy" (Mattison, 2018). Whether intended or unintended, cyber communication has inched its way into professional service relationships, and this trend is likely to accelerate. Clients are more likely to be the initiators of cyber contact with social workers, often without the intentional consent of the clinician. Even when texting and emailing are initiated exclusively for scheduling purposes, workers fear the potential boundary crossings and violations that may arise when the relationship strengthens and clients feel increasingly comfortable sharing therapeutic dialogue in email exchanges. Although the advantages of digitally communicating with clients are many and include client preference, client empowerment, increased therapeutic contact and buttressing the therapeutic relationship, convenience, improved accessibility, and feelings of safety and reduced vulnerability, these must be balanced against identified risks (Mattison, 2018).

Known risks include threats to privacy and confidentiality, lack of formal training in text-based counseling techniques by practitioners, unequal access based on socioeconomic status, misinterpretation of written messages, missed verbal and nonverbal cues, technology glitches, and access to computer-mediated communications by unauthorized and unintended recipients (Mattison, 2018). Social workers are cautioned to avoid addressing client problems in an online format if the practitioner lacks the expertise to treat a similar problem in person. The therapeutic communication skills required to establish online relationships with clients are decidedly different from those used in face-to-face encounters. A clinician skilled in face-to-face communications and interventions cannot assume that these skills will instinctively transfer to text-based competency in the online environment. Because digital technologies pose greater risks to client privacy and confidentiality, clients must be fully apprised, in writing, of the risks

associated with this newly emerging practice modality. At a most elementary level, security measures such as encryption and authentication become the social worker's responsibility to arrange (Mattison, 2018).

Clients must provide expressed agreement to engage in digital exchanges with the social work practitioner to ensure "that the convenience of new technologies does not override the professional values of client self-determination, informed consent, and confidentiality." Detailed informed consent policies addressing the distinct nature of e-practices will assist social workers in circumventing ethical conflicts by documenting that clients knowingly and willingly understand and assume the risks to privacy. Media policies must be thoughtfully developed to reflect the individual social worker's policies and practices regarding a variety of digital media platforms. In cases where clients repeatedly fail to adhere to the agreed-on parameters or the digital exchanges prove to be counterproductive to the therapeutic goals, social workers should reserve the right to limit or terminate the electronic communication exchanges and require clients to meet face-to-face. Before consenting to employ distance professional services, a social worker must assess each client's suitability for this treatment method to determine if e-services are a viable alternative to in-person treatment. Social workers must be knowledgeable about state and licensing provisions for billing and reimbursement and whether e-services are reimbursable under telemental health service provisions in their jurisdiction. Therapists should have an informed consent that addresses Email, Text, and Social Media Policy (Mattison, 2018).

Consideration should be given to a number of different confidentiality challenges that do not arise in face-to-face office visits. The rapid emergence of digital technology and other electronic media used by social workers to deliver services has added a new layer of challenging privacy and confidentiality issues. Fortunately, sophisticated encryption technology can effectively protect client confidentiality, although it is not foolproof. Social workers who offer video counseling services must recognize that they have much less control over confidentiality than when they provide traditional office-based services. For example, a client receiving video counseling services may invite a family member or acquaintance to sit in on a session outside the camera range without the social worker's knowledge or consent (Reamer, 2020).

The code of ethics states, "Social workers should take reasonable steps to protect the confidentiality of electronic communications, including information provided to clients or third parties. Social workers should use applicable safeguards (such as encryption,

firewalls, and passwords) when using electronic communications such as email, online posts, online chat sessions, mobile communication, and text messages" (NASW, 2021).

See Appendix C for sample telehealth informed consent.

Risk Management

Consider the following before implementing telemental health:

- Assess clients for their appropriateness for telemental health
- Provide the client with informed consent and telemental health informed consent
- Create an emergency plan
- Documentation: all correspondence with the client should be documented, including texts, emails, phone calls, and session notes should indicate session occurred via telemental health
- Video telemental health: the product should be designed for healthcare and meet HIPAA compliance standards. There needs to be a business associates agreement between the video provider and the clinician or agency. Features that should be considered include self-view, multi-caller, screen share, chat, and recording.
- Other consideration: secure wi-fi vs. public wi-fi
- Be aware of your jurisdiction and licensure expectations regarding telemental health, be aware that laws change based on state, and that while some exceptions were made during the COVID-19 Pandemic are now being revoked.
- When licensed or working in multiple jurisdictions, the clinician must be aware that laws may differ across states regarding the age of consent for services, records retention requirements, the duty to warn, mandated reporting, etc.
- Phone telehealth: issues, particularly with mobile devices, include info security (many mobile providers and phones track and store data), privacy, and confidentiality can be a concern depending on where the client is participating in the session and who is around or could be around
- Email should use an encrypted service vs. public email service, and many electronic health record programs incorporate email or client portal communications that are HIPAA compliant. Email is frequently not secure, and

clients should be made aware of this in the informed consent form (Barnwell, 2020).

An additional risk management strategy for email can include a signature with a security notice and a disclaimer. See the example below:

IMPORTANT NOTICE: This email transmission and any attachments are intended for the use of only the individual or entity to which it is addressed. It may contain information that is privileged, confidential, or exempt from disclosure under applicable federal or state laws. If the reader of this transmission is not the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this transmission in error, please delete the message and notify me immediately by email: _____@gmail.com or by telephone: 123-456-7890.

Please also note that email is not a secure or confidential form of communication. Information communicated via email may not be private or confidential due to the practices of Internet Service Providers, email providers, or others. Your use of email communication with Dr. Smucker Barnwell constitutes understanding and implied consent of the risks, as well as consent for reciprocal use of email by Dr. Smucker Barnwell for communication purposes (Barnwell, 2020).

Case Study

A behavioral health provider works in a rural area and has expanded his practice to include telehealth services. He hopes to provide counseling to more people who struggle in his state to access mental health care due to its rural nature. While only marketing his telehealth services for a few months, his practice has expanded greatly, and inquiries for services have started to come in from neighboring states who also have a high population of rural residents. He is excited he has been able to identify a gap in mental health services and to be offering a service that helps meet this need. When he has his bi-monthly clinical consultation group, he is surprised when his peers bring up a number of concerns regarding telehealth that he was unaware of. Initially, he was offended by their negativity, dismissing some of their "issues" as not being flexible to shift with the times and fearing technology. Later that day, he visited his state's division of his professional association and his state licensing board and learned there were steps he should have implemented before offering services online.

Discussion

Telehealth competence is a key issue surrounding offering services online. While the clinician had good intentions and did provide telehealth sessions on a HIPAA-compliant platform, he had no prior experience with telehealth. Should there have been an issue with a client, it could be argued he was not competent in providing online services. To address this, he should complete training on providing telehealth services, preferably one that is specific to his state, as many state laws are different.

The provider was excited to start working with those he knew did not have access to mental health resources, but he failed to thoroughly evaluate the appropriateness of offering telehealth services. This would have been something addressed if he had completed telehealth providers' training. (See Appendix B for an example of a Telehealth Appropriateness Screening).

Informed consent and emergency planning are other important considerations when providing telehealth. The provider was having his online clients complete the same informed consent as his in-person office clients, which did not address telehealth-specific consent that should be given. He had not considered what he would do should one of his telehealth clients have an active suicide plan or a health emergency. Moving forward, he should have each client complete an emergency plan and confirm that information is still accurate at the start of each session (See Appendix C for an example of Telehealth Informed Consent & Emergency Plan).

Before providing telehealth services to clients in other states, the provider needs to verify licensing requirements. Many states still require behavioral health providers to be licensed in their state, even when offering telehealth services. When providing services in other states, it is the professional's responsibility to know and follow the state laws in which the client is located. This includes the duty to warn and mandated reporter laws.

Electronic Health Records

The use of information technology to process, store, and retireve information may result in errors. Perhaps the most common is accidentally charting information or placing orders on the wrong patient. While electronic health records (EHR) provide more clearly written information, they also may also lead to charting information on the wrong patient. Currently, no regulatory agreed-upon design standards successfully limit potential errors (Rodziewicz et al., 2022).

Some challenges with EHR include:

- Electronic records often decrease clinician efficiency. Clinicians report that the computer comes between them and the patient and creates constant distractions.
- Some EHRs are designed to be additive, and it may be impossible to correct prior errors. This can lead a clinician to propagate forward incorrect information.
- The tendency to "copy and paste" can represent a significant source of error (Rodziewicz et al., 2022).

With the deployment of electronic records, three phases of medical malpractice risk have been recognized. They include the following:

1. Implementation phase. During this phase, practitioners acquire new skills and learn a novel system. Thus, lack of or inadequate training with implementation during this phase leads to new errors.
2. Transition phase. During the move from a paper record or from one computerized system to another, records can be misplaced or incorrectly added to a patient's record.
3. Mature phase. System-wide failures, such as server errors or intranet failures, may occur, creating chaos and interfering with documentation (Rodziewicz et al., 2022).

Errors in Communication

Verbal Errors

Verbal communication errors are a common source of medical errors. The following are risk factors for verbal errors:

- Disruptive behavior, such as vulgar language or verbal abuse.
- Cell phones, pagers, and phones contribute to environmental noise.
- Cultural differences exist between patients and providers.
- Problems with hierarchy.

- Providers are acting on their own.
- Personality differences.
- Language barriers.
- Inability to work as a team.
- Several conversations are going on at the same time.
- Socioeconomic variables, such as education and literacy (Rodziewicz et al., 2022).

Prevention of Verbal Communication Errors

- A courteous and respectful workplace in which the interprofessional team collaborates and promotes a safe work environment for all members of the healthcare team, their families, and patients.
- Risk management committees and interprofessional task forces should work together to assess and reduce risks.
- Joint education programs help providers and support staff learn roles and develop relationships to improve safety.
- Healthcare organizations should maintain policies that require printed prescriptions. If verbal orders are given, they should be read back and receive confirmation.
- The Joint Commission's Safety Goals require that for critical test results and verbal or telephone orders, a "read-back" is required by the person receiving and recording the result or order, who must read back the order verbatim to the practitioner. The practitioner should verbally acknowledge the order's accuracy.
- Clinicians should follow well-communicated protocols that guide care and communication. Providers should listen to patient questions concerning how care is delivered. Concerns must be respected and accepted as correct and documented if contrary to established evidence-based medicine.
- Providers need to help patients with the information they need to know about their care. Well-informed patients avoid serious medical errors.

- The Joint Commission has supported "Speak Up" initiatives, which encourage hospitals to inform patients about the importance of their contributions to the care they receive. To make patients active participants in avoiding medical errors, encourage patients to ask about unfamiliar tests, unplanned diagnostic tests, and medications and to verify the correct surgical site (Rodziewicz et al., 2022).

Written Errors

Frequent areas of written errors include using non-standard abbreviations, illegible handwriting, failure to question inappropriately written orders, and failure to complete correct specimen labeling.

Prevention of Written Errors

Staff should never be reprimanded for questioning orders. When writing orders or prescriptions, clinicians should:

- Avoid @ (use "at").
- Avoid < or > (use "less than" or "greater than").
- Avoid a trailing zero (0.1 mcg, not 0.10 mcg) and Write a zero before a decimal point dose (0.1 mL, not .1 mL)
- Avoid abbreviations that look alike, such as QD, QOD, U, IU, and HS.
- Avoid handwriting orders and prescriptions; if necessary, print them.
- Avoid medical abbreviations, like MgSO4 for magnesium sulfate, cc (use "mL" or "milliliters"), or µg (use "mcg" or "micrograms") (Rodziewicz et al., 2022).

Consequences of Medical Errors

Effects of Errors on Clients

Despite the provider's best efforts, medical error rates remain high, resulting in significant disability and death. Medical errors are one of the leading causes of death in the United States. Preventable medical errors contribute substantially to healthcare

costs, including higher health insurance costs per person expenses (Rodziewicz et al., 2022).

Some errors have minimal to no impact on patients. In those cases, clinicians may not even be aware an error has happened. Others have major consequences for patients and their families. Due to an error, patients may experience physical discomfort, emotional distress, the need for additional therapy or procedures, an increased and prolonged hospital stay, a worsening of disease, permanent disability, or death. Distressful consequences the family members may experience include worry, anger, and guilt, particularly if they were involved in making treatment decisions (Wu et al., 2019)

Effects of Errors on Clinical Staff

Healthcare professionals experience profound psychological effects due to real or perceived errors, such as remorse, anger, guilt, shame, fear, feelings of inadequacy, depression, and suicide. The threat of pending legal action may exacerbate these feelings. This can also lead to a loss of clinical confidence. Clinicians equate errors with failure, with a breach of public trust, and with harming patients despite their mandate to "first do no harm.". Self-perceived errors have been associated with decreased quality of life, depression, and burnout among physicians. Some physicians report persistent negative psychological effects and impacts on their careers from mistakes that they have made (Rodziewicz et al., 2022; Wu et al., 2019).

Effects of Errors on Client-Clinician Relationship

The client-clinician relationship may be harmed by mistakes, depending on the severity of the outcome for the patient and the quality of communication between clinician and client. Learning about a mistake may cause the client alarm and anxiety, potentially damaging the client's faith and confidence in the clinician's ability to help. There may be anger, erosion of trust, decreased respect, or feelings of betrayal that diminish openness. Clients may become disillusioned with behavioral health care in general, leading to a reduction in their adherence to treatments or habits.

If the clinician and client can discuss their emotions directly and with mutual understanding and acceptance, the relationship will likely endure; it may even deepen with time. The negative effect of a mistake on the clinician-client relationship may also be mitigated if there is a history of shared decision-making, which diffuses the clinician's responsibility, especially when there has been uncertainty about treatment.

Mistakes reported by the media can damage public trust in the medical and behavioral health professions. A loss of credibility can damage public health as it may discourage some people from seeking care or implementing healthy behaviors (Wu et al., 2019).

Responding to Medical Errors

Responding to One's Own Errors

The way a clinician responds to mistakes can turn these experiences into powerful opportunities for learning and personal growth. After recognizing that a mistake has occurred, the first step is to take any corrective action possible. Other important steps include:

Beginning one's own coping process

Effective coping can prevent unhealthy responses such as denial, cynicism, and excessive concern. The use of effective coping strategies can also play a role in modulating clinician stress and increasing work satisfaction. Coping may happen from a problem-focused mode, in which coping is directed at the problem causing the distress, or an emotion-focused mode which coping is directed at managing the emotional distress caused by the problem.

Accepting responsibility is a prerequisite for a person learning from a mistake, and clinicians who cope by accepting responsibility for their mistakes are more likely to make constructive changes in their practice. However, they are also more likely to experience emotional distress.

Disclosure to the client and family

It is difficult to disclose mistakes to clients or their families. Numerous reports suggest that clinicians are reluctant to tell clients about errors. Studies suggest providers have conflicting feelings of responsibility to the client, colleagues, institution, and themselves. These feelings are complicated by fears, anxieties, and uncertain self-efficacy and outcome expectancy. There are many barriers to disclosure, including fear of damaging one's reputation as well as fear of disciplinary action and litigation.

Disclosure and discussion of an error with the client or family can be made easier by taking a few preparatory steps. Providers should first try to acknowledge their own emotions. Before approaching the client or family, it may be helpful for providers to perform a simple relaxation exercise and to remind themselves that the event and present feelings do not define them as either a caregiver or a person. Rehearsing a few simple, direct statements ahead of time can provide a road map in this awkward moment. When meeting the client or family, the provider should make a brief, direct statement followed by a genuine apology. Such directness may help avoid the kind of long and rambling discussion that often increases anxiety for both provider and client.

Disclosure to colleagues and the health organization's risk management department

It may be very important for colleagues to know about a mistake, especially if they are also providing care for the client, either as a supervisor or as other team members. Knowing about a mistake can benefit the institution, enabling it to provide assistance in handling the mistake, help individuals appreciate the causes or significance of the incident and learn from it, and to prevent future occurrences. Providers seem reluctant to tell their colleagues about mistakes. Some providers report they find the discussion both threatening because of the fear of judgment by colleagues and unhelpful because of the tendency of colleagues to minimize the event. Discussing mistakes with colleagues, however, serves the purpose of problem-focused coping: correcting the situation that led to the mistake. Sharing mistakes with colleagues can also prevent isolation and start the necessary healing process of remorse and learning.

Attempting to learn from the incident

Changes in practice often follow medical errors. These changes can be constructive or defensive. Constructive changes include paying more attention to detail, confirming clinical data personally, changing protocols for diagnosis and treatment, increasing self-care, changing methods of communication with staff, and being willing to seek advice. Institutions can also take constructive action in an attempt to prevent future errors. Defensive changes include an unwillingness to discuss the mistake, avoidance of similar clients, and possibly ordering additional tests. Institutional defensive changes are often linked to judgmental or punitive responses.

Providers were more likely to experience constructive changes if the mistake was caused by inexperience or faulty judgment in a complex case; they were less likely to do so if

they believed that the mistake was caused by job overload. Providers who responded to the mistake with greater acceptance of responsibility and more discussion were also more likely to report constructive changes.

The emotions that occur as a result of the mistake can affect learning. When negative emotions such as shame, guilt, or humiliation follow from the mistake, the provider's energy may focus on the emotional aspects of coping. Addressing these negative emotions can enhance the provider's ability to learn new information or new approaches to the problem. Failure to appreciate these emotions can lead to denial (Wu et al., 2019).

Responding to Colleagues' Errors

When a colleague has committed a healthcare error, it is important to accept the individual's self-assessment and not minimize the importance of the incident. Other responses, if appropriate, may include

- A discrete disclosure of one's own mistakes may reduce the colleague's sense of isolation and encourage discussion.
- An inquiry about the emotional effect of the error and how the colleague is coping with it.
- Not trying to problem-solve negative emotions but acknowledging them as a way to mitigate lasting effects.
- Explore the content of the mistake and help the colleague correct it, making the necessary changes in practice and incorporating the lessons learned.

When responding to errors, institutions can support employees by providing safe settings where clinicians can share mistakes and their emotional impact and where corrections can be made to the culture of perfectionism. By providing a mutually supportive approach, the experiences can lead to substantial learning. Another approach some institutions have taken is creating a "second victim" response team. Here, a team of trained clinicians provide emergency peer support to clinicians involved in a traumatic patient-related event. Additional levels of support are then offered in the days and weeks following the event, depending on the clinician's needs (Wu et al., 2019).

Witnessing a Colleague's Error

A provider witnessing an error made by a colleague may choose to respond in one of the following ways. Each response has its pros and cons.

- Waiting for the provider to disclose to the patient - while this is the easiest option, there is no guarantee the patient will be informed of the mistake.
- Advising the provider to disclose the mistake may address the observing provider's requirement for disclosure, but there is still no guarantee the patient will be informed.
- Telling the patient oneself - telling the patient may be awkward, particularly if the observing provider does not have a relationship with the patient. It could also be damaging to the treating provider-patient relationship.
- Arranging a joint meeting to discuss the mistake - simultaneously advising the provider and the institution's quality-assurance or risk-management personnel increases the likelihood that the patient will be told. A joint meeting can reassure the observing provider that a disclosure is made while preserving the relationship between the patient and the treating provider.

While a provider may have an ethical obligation to report an observed error, many are reluctant to do so. Barriers to reporting and discussing observed errors include fear of eliciting anger and threatening relationships with colleagues or referral sources (Wu et al., 2019).

Institutional Responses

Institutional responses should aim to create safe cultures that allow for learning from adverse events. A safe culture:

- encourages clinicians to be aware of the potential for error,
- includes system thinking in their everyday practices,
- provides adequate data regarding errors to managers.

Risk management departments can promote comprehensive, supportive forums for discussing mistakes and for using emotion-focused coping to maximize problem-focused learning and minimize future errors. Creating safe spaces that encourage reporting and

addressing errors leads to minimizing blame, denial, and repeated problems (Wu et al., 2019).

Reporting Errors

Healthcare professionals are often reluctant to report errors for fear of punishment. While they have concerns for patient safety, they also fear disciplinary action, including the worry of losing their jobs for reporting an incident. Unfortunately, failing to report contributes to the increased likelihood of serious patient harm. Many healthcare institutions have strict policies in place that create an adversarial environment. This can contribute to staff hesitation to report an error, minimize the problem, or fail to document the error. These actions, or lack of action, can play a part in a never-ending cycle of medical errors. When these errors eventually come to light, they can ruin the reputation of the healthcare institution and the employees (Rodziewicz et al., 2022).

Error rates are typically higher in stressful, fast-paced environments such as emergency rooms, intensive care units, and operating rooms. Medical errors are linked to advanced age, high acuity, and new procedures. Errors frequently occur when necessary personnel are unavailable as required. An incomplete preoperative assessment may occur when multiple practitioners are involved. Due to time constraints or a lack of understanding of their abilities, students, interns, residents, and fellows may be under-supervised (Rodziewicz et al., 2022).

Errors usually occur with the convergence of multiple contributing factors. Some errors may not be preventable with the resources available to the practitioner or the current technology. Human factors are always a concern, and identifying errors permits improvement strategies to be undertaken. Blaming or punishing individuals for errors involving systemic causes does not address the issues nor prevent a repetition of the error. Patient safety experts need to focus on improving the safety of healthcare systems to reduce the likelihood of errors and diminish their effects, rather than focus on an individual's actions. Errors are an opportunity for constructive changes and improved education in healthcare delivery. Institutions should strive to find ways to limit errors while removing blame but maintaining accountability (Rodziewicz et al., 2022).

The purpose of reporting error-prone situations is to reduce future medical errors. Numerous studies have identified that if error-prone situations are reported and managed by modifying the system, a decrease in the frequency of the error and related errors associated with it will occur. Therefore, after medical errors have been reported,

an analysis must be made so institutions can make necessary changes to avoid similar events in the future. Two types of analysis are discussed below.

Root Cause Analysis

Root cause analysis reviews sentinel events that result in psychological or physical injury or death. A sentinel event starts an investigation that determines the cause(s) and enhances the procedures and systems to reduce the likelihood of a repeat occurrence. It is intended to assist in identifying the root or underlying causes of mistakes. The members of the RCA team are primarily concerned with systems and procedures, not with individual behavior. The team finds ways to improve performance and lessen the recurrence of the same sentinel event by making improvements to systems and procedures.

Failure Mode Effects Analysis

Failure mode effect analysis is a proactive method of identifying possible or actual failures, causes, and consequences to promote safety and the prevention of accidents. Failure mode effect analysis acknowledges that errors will still happen even if healthcare personnel are careful. Failure mode effect analysis participates in the process of continuous quality improvement to identify and address areas where an error has happened or is likely to happen. The failure mode effect analysis strategy is building redundancy to act as an error-catching safety net (Rodziewicz et al., 2022).

Medical Errors and Burnout

Burnout is a psychological syndrome characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. Due to the demands of treating people with psychological problems, burnout is prevalent among psychotherapists. Burnout affects psychotherapists' general well-being and the extent to which clients engage in and benefit from psychotherapy. Risk and protective factors influencing burnout include:

Perceived job control: Job control refers to how employees can make autonomous decisions about work tasks and are able to fulfill their responsibilities. Research shows a correlation between a lack of perceived job control and emotional exhaustion and reduced feelings of personal achievement.

Job Demands: Job demands include physical (e.g., workload, hours of work) and psychological (e.g., empathizing with clients and developing treatment plans). Increased job demands lead to increased emotional exhaustion, leading to a greater risk of burnout.

Workload and caseload: Workload is considered the number of hours one works. Research shows that increased workload is positively correlated to increased emotional exhaustion and decreased feelings of personal accomplishment. Caseload is the number of clients one is responsible for seeing regularly. There is a positive correlation between caseload size and emotional exhaustion and depersonalization.

Countertransference reactions: One study found countertransference to be a warning sign for burnout. Countertransference can gradually erode psychotherapists' compassion for their clients and energy for their jobs. Gradually, psychotherapists might be at risk of losing the inner resources necessary to cope with stress and be more vulnerable to emotional exhaustion and decreased feelings of personal accomplishment when they lose a sense of equanimity with their clients.

Psychotherapists' mental health history: Some research suggests that being personally familiar with and overcoming a problem that is similar to one's client might protect psychotherapists from burnout.

Supervisory support: Support from one's colleagues and supervisors has been shown to reduce emotional exhaustion and increase feelings of personal accomplishment (Yang & Hayes, 2020).

Effects of Burnout

Physical well-being: Burnout can appear as flu-like and gastrointestinal symptoms, sleep deprivation and insomnia, and back and neck pain.

Psychological well-being: Burnout can increase the risk of developing anxiety and depressive disorders, suffering secondary traumatic stress, and experiencing general psychological distress.

Job satisfaction and turnover: Burnout consists of depersonalization, emotional exhaustion, and feelings of personal accomplishment, all of which are linked to increased job turnover.

Effectiveness: Depersonalization is linked to poor client outcomes, this may be due to the psychotherapists' inability to express empathy and build rapport with their clients, which could impede their effectiveness and lead to poor treatment outcomes. The reduced sense of personal accomplishment resulting from burning out decreased their productivity and motivation. The specific effects of burnout included reduced empathy, difficulty building therapeutic alliances, more frequent mistakes, impaired communication skills, and attention difficulties.

Client engagement & outcomes: Psychotherapist burnout was linked to client disengagement and discontinuing services. One concern is that psychotherapists experiencing emotional exhaustion may experience decreased energy or attention as well as self-protective denial in their work and, therefore, might be unable to recognize the impact burnout has on themselves or their clients (Yang & Hayes, 2020).

Preventing Burnout

Psychotherapists should monitor themselves on a continual basis for early signs of burnout and identify strategies to actively reduce and prevent burnout. Examples of adaptive coping strategies include mindfulness practices, obtaining emotional support from colleagues, supervisors, friends, and family, and balancing work demands with leisure activities.

Psychotherapists who have particularly demanding caseloads, whose job autonomy is restricted, or who are struggling with distress in their personal lives particularly need to prioritize self-care activities, such as not overworking (when possible), seeking psychotherapy for oneself, and maintaining boundaries with clients (e.g., limiting phone contact between sessions). Clinicians can participate in peer supervision as another way to combat burnout (Yang & Hayes, 2020).

A Stanford University School of Medicine study found that physician burnout is as impactful on medical errors, if not more so, than unsafe medical workplace conditions. This makes it even more pertinent to identify and address the issues that lead to burnout in the healthcare profession. 55% of the physicians surveyed for the study reported symptoms of burnout. Additionally, 10% reported that they had made at least one major medical error in the past three months. Physicians with burnout had more than twice the odds of self-reported medical error. Hospitals and clinics that received low safety grades in the study were found to have three to four times the number of medical errors. Other studies have found half of the physicians experience burnout symptoms of exhaustion, cynicism, and feelings of reduced effectiveness. Burnout, in

turn, impacts the quality of care, patient safety, turnover rates, and patient satisfaction. While many organizations invest in programs to address safety on a systems level to reduce medical errors, little attention is given to system factors that lead to physician burnout. The study also showed that rates of medical errors tripled in medical work units, even those ranked as extremely safe if physicians working on that unit had high levels of burnout. This indicates that burnout may be an even bigger cause of medical error than a poor safety environment. This new research addressing medical errors needs to go beyond workplace safety and fix systems with checklists and improved teamwork. Healthcare provider burnout needs to also be addressed. Medical errors and burnout not only affect patients but also have serious personal consequences for providers. Research shows that both burnout and medical errors independently double the risk of suicidal thoughts among physicians, contributing to a higher risk of death by suicide among physicians when compared to other professionals." (White, 2018).

Preventing Errors

The highest priority for providers and institutions is to reduce the frequency and severity of medical errors. Errors happen on multiple levels; therefore, multiple areas can be addressed to reduce errors.

Individual Providers

While accepting responsibility for mistakes is crucial, it is also emotionally distressing. Colleagues and supervisors need to respond with sensitivity to the distress of providers acknowledging their mistakes. The probability of future mistakes can be reduced if the current error can be reviewed in a way that decreases emotional distress, invites disclosure of uncertainty in diagnosis and management, and leads to a discussion of appropriate changes in practice (Wu et al., 2019).

Developing self-awareness can be a vital corrective action to cognitive biases. Learning mindfulness skills can help clinicians be aware of the emotional and contextual conditions where they are more likely to engage in cognitive shortcuts that lead to diagnostic errors. They can learn to default to high-level decision rules, for example, looking beyond early hypotheses when they perceive themselves as impatient, fatigued, or anxious for a quick resolution (Wu et al., 2019).

Other safety strategies that can be implemented to prevent errors include:

- consistent use of a reliable method to verify patient identity,
- use of metric measurements,
- adequate workplace illumination and organization.
- all drug orders are to be in English rather than in Latin, apothecary script, or shorthand abbreviations that are all subject to misinterpretation.
- eliminating abbreviations and acronyms,
- providing up-to-date information at the point of care,
- and partnering with patients regarding their own safety (Wu et al., 2019).

Administration and Supervision

Efforts to mitigate errors must begin at the administrative level. Acknowledgment by the leadership of the inevitability of errors and making patient safety a priority are crucial in creating institutions that learn from their mistakes. More active clinical supervision may prevent some mistakes or mitigate their adverse effects. Senior providers can mentor less experienced colleagues regarding critical decisions about patient care, especially in complex cases that require experienced clinical judgment. The administration should address problems in staffing, scheduling, and the nature of work, all of which may contribute to mistakes. In addition, optimizing handoffs between different providers and care locations should also be considered (Wu et al., 2019).

Serious attention must be paid to the workload. Sleep deprivation is a known source of errors; job overload and fatigue can also lead to mistakes. Working under strained conditions may lead to supervisors tolerating and rationalizing errors, and it may make them less likely to seek the corrective information that could help prevent future mistakes. All providers, regardless of experience or status, are vulnerable to the effects of sleep deprivation, which erodes the executive functions of the brain and leads to more failures of attention (Wu et al., 2019).

Identifying and Reporting Errors

Investigation and root cause analysis to explain the causes of adverse events often suggest specific strategies for preventing future harm. This is aided by routine mechanisms to identify adverse events, such as anonymous reporting by physicians and

nurses. Developing routine methods of conveying information, such as computerized cross-coverage templates that standardize the type and amount of information exchanged between covering physicians, can also reduce errors (Wu et al., 2019).

It is important to take special care with newer medications, “look-alike/sound-alike” medications, and “high alert” medications that should be handled with deliberation (Wu et al., 2019).

Workplace Design

Changes can be made to the physical design and layout of work areas to improve safety. Some of these changes are intended to overcome barriers to following good practice. For example, compliance with hand hygiene guidelines can be improved by optimizing the design features of alcohol hand gel dispensers. Improving air quality using laminar floor ventilation, automatic doors, and single bedrooms can reduce airborne pathogens and infections. Lighting that follows night/day cues can increase patient comfort, whereas noise reduction using sound-absorbing tiles can reduce distraction and subsequent degradations in performance and burnout (Wu et al., 2019).

Computerized Systems

Computerized systems can detect and avert medication errors, including overdoses, incorrect routes of administration, drug interactions, and allergies. Computerized order entry systems, automated medication-dispensing machines, and barcoding of medications, blood products, and patients have been shown to reduce the incidence of adverse events (Wu et al., 2019).

New technology must be introduced in a way that addresses the risks and benefits. Healthcare workers must receive sufficient preparation and training so that technologies are not disruptive or that they do not become inadvertent sources of error. There are risks entailed in an overreliance on automation in which vigilance becomes dulled (Wu et al., 2019).

System-wide adoption of IT interventions, such as computerized prescriber order entry (CPOE), bar coding of medications and patients, and using Electronic Health Records (with drug interaction alerts and clinical support system), can reduce cognitive errors in diagnosis as well as pharmaceutical errors. Bar codes have a complementary role with decision support systems in computerized order entry, which prevent errors associated

with bad judgment and lack of knowledge. One study found that implementing CPOE was associated with a reduction in hospital-wide mortality. While implementation is expensive, it allows for standardization of communication with staff and can lead to improved turnaround times for patients (Wu et al., 2019).

General Strategies to Reduce Risk

The following is an overview of numerous steps behavioral health providers can take to reduce risks for medical and clinical errors that can negatively affect their clients, their client's families, the provider themselves, their colleagues, and the community. Mistakes can have long-reaching impacts beyond the therapy session.

- Therapists should always document psychotherapy sessions.
- In difficult cases, therapists should obtain supervision when necessary.
- It is important for therapists to understand the duty to warn laws.
- Therapists should abide by boundaries – a patient is always a patient.
- Intern training programs should instruct trainees on potential areas of liability in psychotherapy.
- Abiding by ethical guidelines instituted by organizations the therapist belongs to, such as the National Association of Social Workers, may help prevent liability.
- Therapists should always document sessions, perform an adequate assessment, make an adequate diagnosis, and develop and implement a reasonable treatment plan.
- Suicide risk should be reassessed on an ongoing basis, especially when changing the level of care. Consultants and/or peer supervision should be used when needed, including case conferences if available.
- A patient's privacy should be protected.
- Therapists should set and respect boundaries; sexual contact with a current or former client is considered unethical and may be illegal.
- Therapists should obtain informed consent from patients before beginning treatment and continue to practice obtaining informed consent throughout the

treatment. It is an ongoing dialogue, not a one-time event. This includes informing the patient of alternative treatments.

- Therapists should not allow discharge decisions to be driven by insurance coverage.
- Therapists should never alter a treatment record after an adverse event
- Therapists should not enter into a dual role or multiple relationships with a patient if it can be avoided
- Therapists should not self-disclose excessively
- Therapists should not use psychotherapeutic techniques that are experimental or unproven and not use psychotherapeutic techniques without proper training.
- Where possible, do not have out of "office" (whether a physical or virtual office) contact with patients (Rosenbaum & Holmberg, 2022).

Conclusion

Understanding clinical risk management in behavioral healthcare is essential for building safer health systems and improving client safety. Clinical errors can have minor to no consequences to all involved or can be extremely detrimental, possibly leading to death in the most extreme circumstances. While behavioral health errors are inevitable, all means should be taken to minimize the potential risks. When errors do occur, individuals and institutions should review the mistake and make necessary changes to prevent future similar mistakes. Support should be provided to clinicians and staff after an adverse event has occurred to reduce distress, promote learning, and implement changes in practice. Recognizing and dealing with errors can enhance the safety for clients, clinicians, organizations, and communities.

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Appendix A: Columbia-Suicide Severity Rating Scale (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT VERSION

(* elements added with permission for Lifeline centers)

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical

record(s) and/or consultation with family members and/or other professionals.

Suicidal and Self-Injury Behavior (Past week)			Clinical Status (Recent)
	Actual suicide attempt	Lifetime	Hopelessness
	Interrupted attempt	Lifetime	Helplessness*
	Aborted attempt	Lifetime	Feeling Trapped*
	Other preparatory acts to kill self	Lifetime	Major depressive episode
	Self-injury behavior w/o suicide intent	Lifetime	Mixed affective episode
Suicide Ideation (Most Severe in Past Week)			Command hallucinations to hurt self
	Wish to be dead		Highly impulsive behavior
	Suicidal thoughts		Substance abuse or dependence
	Suicidal thoughts with method (but without specific plan or intent to act)		Agitation or severe anxiety
	Suicidal intent (without specific plan)		Perceived burden on family or others
	Suicidal intent with specific plan		Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
Activating Events (Recent)			Homicidal ideation
	Recent loss or other significant negative event		Aggressive behavior towards others
	Describe:		Method for suicide available (gun, pills, etc.)

			Refuses or feels unable to agree to safety plan
	Pending incarceration or homelessness		Sexual abuse (lifetime)
	Current or pending isolation or feeling alone		Family history of suicide (lifetime)
Treatment History		Protective Factors (Recent)	
	Previous psychiatric diagnoses and treatments		Identifies reasons for living
	Hopeless or dissatisfied with treatment		Responsibility to family or others; living with family
	Noncompliant with treatment		Supportive social network or family
	Not receiving treatment		Fear of death or dying due to pain and suffering
Other Risk Factors			Belief that suicide is immoral, high spirituality
			Engaged in work or school
			Engaged with Phone Worker *
		Other Protective Factors	

Describe any suicidal, self-injury or aggressive behavior (include dates):

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.*	**Lifetime : Time He/She Felt Most Suicidal**	**Past 1 month**
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 wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes No** ☐ ☐	**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 actually had any thoughts of killing yourself?*** If yes, describe:	**Yes No** ☐ ☐	**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 been thinking about how you might do this?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes No** ☐ ☐	**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 started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes No** ☐ ☐	**Yes No** ☐ ☐
INTENSITY OF IDEATION		
The following features 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). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** ____ _____ ***Type # (1-5)*** ***Description of Ideation*** Recent ***- Most Severe Ideation:*** ___ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day		

Duration

When you have the thoughts how long do they last?

(1) Fleeting - few seconds or minutes

(2) Less than 1 hour/some of the time

(3) 1-4 hours/a lot of time

(4) 4-8 hours/most of day

(5) More than 8 hours/persistent or continuous

Controllability

Could/can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts

(2) Can control thoughts with little difficulty

(4) Can control thoughts with a lot of difficulty

(5) Unable to control thoughts

Deterrents

Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide

(2) Deterrents probably stopped you

(4) Deterrents most likely did not stop you

(5) Deterrents definitely did not stop you

Reasons for Ideation

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others

(2) Mostly to get attention, revenge or a reaction from others

(3) Equally to get attention, revenge or a reaction from others

(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)

(5) Completely to end or stop the pain (you couldn't go on and to end/stop the pain living with the pain or how you were feeling)

(0) Does not apply

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
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. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____as a way to end your life?*** ***Did you want to die (even a little) when you_____ _____ ? Were you trying to end your life when you_____ ?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes No** ☐ ☐ Total # of Attempts	**Yes No** ☐ ☐ Total # of Attempts
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes No** ☐ ☐	**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 end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of interrupted	**Yes No** ☐ ☐ Total # of interrupted
Aborted 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 try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of aborted or self-interrupted	**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 taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes No** ☐ ☐ Total # of preparatory acts	**Yes No** ☐ ☐ Total # of preparatory acts

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/ First Attempt Date:

Actual Lethality/Medical Damage: 1. No physical damage or very minor physical damage (e.g., surface scratches). 2. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 3. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 4. 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). 5. 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).	*Enter Code*	*Enter Code*	*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*	*Enter Code*	*Enter Code*

Appendix B: Telehealth Appropriateness Assessment

Risk Management in Telemental Health Sara Smucker Barnwell, PhD

https://adai.uw.edu/nwattc/pdfs/telementalhealth6slides.pdf

Telehealth Appropriateness Assessment

Delivering psychological services through remote technology provides the opportunity to reach clients who might not otherwise receive care. However, not every client will be appropriate for telehealth services. The questions below provide guidance regarding clinical and technical factors that you may wish to consider before committing to deliver telehealth care.

Clinical Assessment

1. What is the patient's age?

a. If a minor, how will you gather the parent's consent?

2. Is the client currently in crisis?

3. In the past 12 weeks, have they had thoughts, intention, or plans to hurt themselves?

a. About hurting someone else?

4. Have they ever been hospitalized for emotional health reasons?

a. When?

b. What happened?

5. Explain that telehealth services typically serve in non-crises. Explain the manner in which telehealth providers support patients who later develop crises, but may need to supplement care with in-person meetings or transfer care.

6. Is this issue related to an accident or legal action that is pending?

a. Are they seeking an assessment related to legal action?

7. Are they hoping to use insurance to pay for your visit?

a. Who is their insurance carrier?

b. Are you/ they familiar with your mental health benefits?

c. With the insurance carrier's policy regarding telehealth?

d. Will you or the client contact insurance to discuss the telehealth policy?

8. Why are they seeking telehealth care vs. in-person care?

a. Is in-person care available in their community?

9. Are they available to meet in person with the provider now or in the future?

10. How do you plan to verify the client's identity?

11. In what state does the client intend to receive care?

a. Does the client intend to travel often while receiving remote care?

Technical Assessment

1. Do they have access to a private space in their home?

2. Is it relatively soundproof? How easily can a conversation be overheard?

a. Explain to the client the critical importance of keeping this space secure and confidential during appointments

3. Do they have access to a computer or mobile device?

a. What kind (e.g., desktop, laptop, tablet)?

b. How old is it (< 7 years old)?

Appendix C: Informed Consent & Emergency Protocols for Telemental Health

Source: Telemental Health Informed Consent - National Association of Social Workers

Retrieved: https://www.socialworkers.org/LinkClick.aspx?fileticket=fN67-dWQReM%3D&portalid=0

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and

a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone:_____ _____ ___

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian _____ Date _____

Signature of therapist _____ Date _____

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