Counselor Spotlight: Managing Clients in Crisis

Healthcare Providers Service Organization (HPSO), in collaboration with CNA, has published our ***Counselor Professional Liability Exposure Claim Report: 3rd Edition***. The report includes statistical data and claim scenarios from CNA claim files, along with information on where to access risk management resources designed to help counselors reduce their professional liability (PL) exposures and improve client safety. You may access the complete report, and additional Risk Control Spotlights, at: www.hpso.com/counselorclaimreport.

This Counselor Spotlight highlights professional liability risks associated with an important topic: **Managing Clients in Crisis** and the essential role of effective assessment in supporting accurate diagnosis. Claim scenarios from the dataset will be used to illustrate these exposures, and the discussion will include strategies to enhance client safety and reduce professional liability risk.

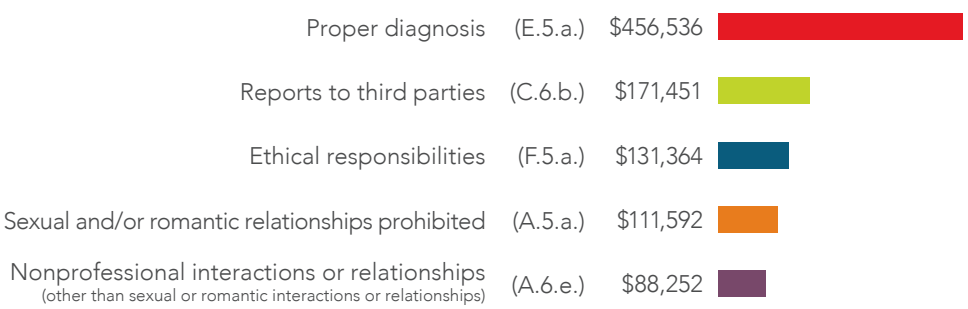
Professional Liability Claims Related to Evaluation, Assessment and Interpretation

Allegations related to "Evaluation, assessment, and interpretation", Section E of The American Counseling Association (ACA) Code of Ethics (2014), were less common than other top allegations, but were associated with multiple high severity claims in the 2024 dataset. Within this category, the sub allegation, Section E.5.a (Proper Diagnosis), accounted for 6.3 percent of claims, with an average total incurred of $456,536 (**Figures 14 and 15**). These claims often involved delays or failures in timely assessment and accurate diagnosis of clients experiencing crisis situations. The highly emotional nature of these claims contributed to the potential for juror sympathy and the above average costs to defend and resolve them. Section E.5.a. emphasizes that counselors must use appropriate assessment techniques to accurately diagnose mental disorders, determine suitable treatment approaches, and recommend follow up care as necessary.

14 **Distribution by ACA Code of Ethics Sub-Sections**
Closed Claims with Paid Indemnity of ≥ $1

* This figure highlights those sub-sections with the largest portion of the distribution

15 **Average Total Incurred by ACA Code of Ethics Sub-Sections**
Closed Claims with Paid Indemnity of ≥ $1



A **crisis may arise** when a client's coping abilities are **overwhelmed** by a **stressful or traumatic** event or by the exacerbation of an existing mental health condition.

Clients in Crisis

A crisis may arise when a client's coping abilities are overwhelmed by a stressful or traumatic event or by the exacerbation of an existing mental health condition. Clients may experience a wide range of crises, including, but not limited to, developmental (major life transitions), situational (divorce), grief, trauma, (violence or natural disasters), substance use and mental health crises (suicidal ideation or major depressive episodes). This *Spotlight* will focus specifically on crises involving suicidality and trauma, with attention to key risk factors and considerations for working with vulnerable or high risk populations.

Suicidality

Treating clients experiencing suicidality requires clinical judgment, comprehensive assessment, and adherence to established standards of care. Suicidality includes the spectrum of suicide-related thoughts and behaviors such as suicidal ideation (passive or active), intent, planning, preparatory behaviors and suicide attempts—all of which signal an elevated risk of self-harm. Suicide remains a major public health concern in the United States (US). National data from the CDC indicates that over 49,000 people in the US died by suicide in 2023, constituting one death every eleven minutes. These statistics underscore the need for comprehensive, evidence based approaches to suicide risk assessment and intervention, as well as tailored strategies for specific at-risk populations.

Special Populations

Identifying suicide risk factors within vulnerable populations is key to establishing prevention strategies and supporting timely diagnosis. This section highlights at-risk populations—children, adolescents and young adults, older adults and clients with a substance use disorder.

Children, Adolescents and Young Adults

According to the American Academy of Pediatrics (AAP), suicide is the 2nd leading cause of death among youths ages 10-24 in the US. In 2021, the AAP, American Academy of Child and Adolescent Psychiatrists (AACAP) and the Children's Hospital Association (CHA) declared this to be a national emergency in child and adolescent mental health. A 2025 updated press release indicated that this trend continues and recommended strategies for prevention, such as earlier assessment and screening for mental health issues in primary care, schools and community settings.

Risk factors associated with suicide in this population include the following, among others:

- Mental health conditions
- Previous suicide attempts
- Family history of suicide
- Domestic violence and community violence exposure
- History of physical or sexual abuse
- Bullying
- Access to lethal means
- Frequent social media use

The following claim scenario illustrates potential PL risks that may arise when counseling an adolescent experiencing suicidality:

- The client, a 16-year-old female student, had completed a 12 week course of weekly counseling sessions in which she presented with anxiety, difficulty concentrating and suicidal ideation without plan or intent. She subsequently discontinued therapy, stating she was "too busy" with school. Six months later, she returned to counseling reporting that she was experiencing severe anxiety and suicidal ideation without a plan for the past several weeks. The counselor did not review her prior clinical notes, relying instead on his familiarity with the client. As the session progressed, the client was observed to be exhibiting signs of agitation—constantly pacing and refraining from making eye contact. The counselor documented that the client's behavior "appeared manic" and that the client seemed to be "in crisis". Based upon these observations and a concern that the client may be experiencing a manic episode, the counselor recommended a psychiatry referral. The client stated that she was not interested in seeing a psychiatrist. The counselor provided the client with the contact information for the psychiatry provider and encouraged the client to reconsider, explaining his concern for her wellbeing. He documented that he would follow up with the client in one week; however, he did not document a risk assessment or safety plan nor did he document an informed refusal regarding the psychiatry referral.

  One week later, the client's father contacted the counselor to report that the client had died by suicide two days following the counseling session. He expressed criticism of the counselor's treatment and was angry that the counselor was unaware of his daughter's recent inpatient psychiatric admission for severe depression. He also reported that the client had attempted to schedule a psychiatry appointment but was told there was a six-month waiting list.

  A lawsuit was later filed by the client's parents alleging that the counselor failed to obtain an adequate history and did not conduct a suicide risk assessment. According to the plaintiff's experts, a review of the client's prior records and updating the client's history would likely have revealed her recent inpatient psychiatric admission for treatment of a major depressive disorder and suicidal ideation. Defense experts were unable to support the case and were critical of the treatment and specifically of the failure to perform a comprehensive suicide risk assessment. During his deposition, the counselor acknowledged that he did not fully recognize the severity of the client's symptoms and conceded that he should have performed a suicide risk assessment. Based upon the above-noted defense challenges, this case was settled for a total incurred of more than $975,000.

Older Adults

A 2025 Harvard study revealed that adults aged 75 and older, have the highest rates of suicide of any age group, and, according to the CDC, the suicide rate for men ages 85 and older is 55.7 deaths per 100,000, with the use of firearms noted as the leading mechanism. Key risk factors for suicidality among older adults

include social isolation and loneliness, decline in health and experiencing bereavement due to a loss of spouse or family member. The following claim scenario reveals the clinical and PL risks in treating this age group and the importance of conducting complete assessments:

- A 79 year old female client with longstanding depression and a substance use disorder began counseling shortly after the death of her husband. On her intake paperwork, the client disclosed a history of suicidal ideation, new symptoms of paranoia and an increased consumption of alcohol. Although she expressed hopelessness—stating, "I will never get better"—the counselor documented in the counseling healthcare information record that the client denied suicidal ideation and left the "danger to self or others" question on the assessment form blank. Follow up visits were planned at two week intervals.

  At the next session, the client described worsening depression, overwhelming sadness, and suicidal ideation without a plan or intent. This time, the counselor documented that the client was a "danger to self/others" and, recognizing that firearms were present in her home, advised her to remove them. The client declined and stated that there was no need to remove the firearms. Six days later, she died by suicide from a self inflicted gunshot wound. Toxicology results revealed significant levels of alcohol, diazepam, and hydrocodone.

  The estate filed a lawsuit asserting that the counselor failed to perform a suicide risk assessment and neglected to develop a collaborative safety plan. The plaintiff's expert testified that the documentation of "danger to self/others" inferred that there was a serious concern for the client's safety that was not addressed. The existence of a "red flag" law was included in the plaintiff's theory of liability during discovery in the case. Red Flag Laws — also known as Extreme Risk Protection Orders (ERPOs) — are state-specific laws that allow courts to temporarily remove firearms from a person who is considered to pose a danger to themselves or others. Defense experts were unable to support the care and opined that the counselor's documentation indicating "danger to self or others," and the client's access to firearms required a comprehensive suicide risk assessment and completion of a formal, collaborative safety plan. The documentation was viewed as a significant defense challenge, as it created a gap between the implied risk and the counselor's treatment plan. This case was settled for a total incurred of more than $500,000.

Clients With Substance Use Disorder

Substance use disorders significantly increase suicide risk due to their effects on impulse control, judgment impairment and mood regulation, and, during crisis periods, may turn suicidal ideation into suicide completion. A 2025 Rand study revealed that substance misuse was associated with a 5.58 higher risk of suicide. It has also been shown that chronic pain increases the risk of suicide for individuals with substance use disorders. Counseling treatment includes dual-diagnosis therapy and cognitive behavioral therapy, among other therapies aimed at improving mood regulation and reducing substance use.

Trauma-Related Crises

Crises related to trauma often involve an event or situation that threatens one's perception of safety. Trauma is indiscriminate and is ubiquitous among clients in counseling. The American Counseling Association maintains that the widespread impact of trauma in society prompted the creation of "trauma informed care," a framework designed to help counselors and other healthcare professionals recognize trauma related symptoms and risk factors. Trauma-informed care utilizes a holistic approach to client assessment and diagnosis and is a valuable tool for counselors to integrate into their practices.

Trauma may arise from a wide range of significant life crises, including—but not limited to—physical or sexual abuse, family dysfunction, exposure to or witnessing violence, and natural disasters. Natural disasters, including severe weather events, pandemics, and large scale fires, can have substantial effects on mental health and frequently precipitate crisis situations. According to the ACA, psychological first aid is the standard approach for individuals who have endured a natural disaster and notes that Critical Incident Stress Management (CISM), a form of psychological first aid, serves as an acute intervention aimed at mitigating crisis related trauma. Its purpose is short term stabilization rather than long term therapeutic treatment.

Spotlights on Risk Management

To supplement the ***Counselor Professional Liability Exposure Claim Report: 3rd Edition***, CNA and HPSO will publish seven Spotlight documents, which will highlight specific topics and provide greater detail on key risk management strategies and client safety practices.

The following Counselor Spotlights include resources such as case studies, risk control considerations, and self-assessment checklists designed to help counselors evaluate and mitigate risk exposures associated with current practice:

- Defending Your License
- Non-Sexual Boundaries
- Telebehavioral Health
- Liability Risks for Business Owners and Supervisors
- Managing Clients in Crisis
- Well-being and Provider Mental Health
- Documentation

Assessing Clients in Crisis

Comprehensive assessment is the foundation of effective intervention when counseling clients in crisis. While multiple assessment tools are available, the selection should align with the client's clinical presentation, known risk factors and mental health history, with the understanding that assessment is an ongoing process. The Columbia-Suicide Severity Rating Scale (C-SSRS) is one example of an assessment tool for identification of suicidality providing screening through a series of questions:

- Has the client been experiencing suicidal ideation?
- Do they have a plan to prepare for suicide?
- Is there an intent to act upon these thoughts?
- Do they have a history of previous suicide attempts?

As stated earlier, traumatic events may often trigger suicidal ideation, particularly if the client has an underlying mental health disorder and, therefore, completing and documenting suicide risk assessments and safety plans coupled with ongoing and real-time mental status examinations should be top of mind. Risk assessment is a dynamic process and should be performed at the initial intake and throughout the treatment period.

Confidentiality

Confidentiality serves as the basis of an effective therapeutic relationship. However, counselors must also be cognizant of the circumstances under which confidentiality is limited. When the assessment reveals a credible risk of harm to the client or to others, a corresponding duty to protect all individuals who may be at risk is triggered. As outlined in the 2014 ACA Code of Ethics, Standard B.2.a, confidentiality may be breached when a client communicates a threat of "serious and foreseeable harm" to themselves or another person. Given these ethical standards, counselors should not only recognize when confidentiality must be limited but also be prepared to respond appropriately when indicated. This transition from confidential care to protective action underscores the importance of understanding the duty to warn or protect.

Duty to Warn

A comprehensive and ongoing risk assessment process equips counselors with the clinical information needed to identify when a higher level of care, additional support, or an emergency intervention is required. The principle of "Duty to Warn" addresses required protective actions in response to when a client communicates a serious and foreseeable threat of harm to themselves or to an identifiable third party. Although the specific legal requirements vary by state, the general principle is that a counselor may breach confidentiality when necessary to prevent harm. Determining when a duty to warn is warranted can be complex, particularly as counselors work to preserve confidentiality in their practice. According to the National Conference of State Legislatures (NCSL), states differ significantly in how they regulate a mental health professional's obligation to warn or protect potential victims. NCSL provides a national map categorizing states as mandatory, permissive, or having no statutory duty.

Key Risk Management Principles

- ☐ Appropriate communication
- ☐ Thorough documentation
- ☐ Well-documented informed consent
- ☐ Detailed client assessment
- ☐ Adherence to state licensing regulations and laws
- ☐ Compliance with the ACA Code of Ethics

The following claim scenario exemplifies the PL exposure related to assessment, confidentiality and duty to warn:

- A 50-year-old client was experiencing anxiety and depression related to an impending divorce. His employer had mandated that he take medical leave following outbursts of anger in the workplace, as well as verbalized threats to harm his spouse. The client's employer contracted with a counseling agency as part of its employee wellness program and required the client to undergo counseling before being allowed to return to work. Over a three-week period, two counseling sessions were conducted by a marriage/family counselor. The client disclosed to the counselor that there were weapons in the home and admitted to having past thoughts of "hurting his spouse." However, at the time of the assessments, the client denied suicidal/homicidal ideation. The assessments included questions pertaining to the client's coping mechanisms and support systems, to which the client responded that he had supportive friends and siblings. Based upon the client's statements, the counselor deemed that the client was not a danger to himself or others and determined that there was no "duty to warn." The counselor advised the employer that the client was cleared to return to work with no restrictions. The following week, the client sent threatening text messages to his spouse, and, later that day, fatally shot his spouse and then himself. A lawsuit was filed by the spouse's family asserting that the counselor failed to perform an adequate mental health assessment to rule out the presence of an imminent threat of "danger to self or others." During litigation, experts were critical of the counselor's assessment and opined that she had a "duty to warn" the client's spouse. They testified that a comprehensive suicidal/homicidal risk assessment was not performed and that a safety plan should have been instituted, that included no access to weapons, based upon the client's recent threats to harm his spouse. The defense team was unable to demonstrate that a well-documented assessment was performed or that appropriate follow-up actions were delineated. The total incurred during settlement was more than $950,000.

Client Follow-up and Emergency Contact Procedures

Counselors should establish and consistently apply clear follow up procedures—such as scheduling timely appointments, conducting proactive outreach, and ensuring clients are informed about how to contact the counselor during business and non-business hours, as well as how to access crisis hotlines, after hours resources, and emergency services. This information should be provided during the initial informed consent discussion, reinforced throughout treatment and documented in the client record. Doing so ensures that clients clearly understand the counselor's availability and the steps to take in the event of an emergency, thereby reducing ambiguity, minimizing gaps in care, and strengthening defensibility should a professional liability claim arise. The following claim scenario illustrates how the absence of clearly communicated emergency contact protocols may create liability exposure:

- A 30-year-old client was undergoing counseling for depression. The counselor was in private practice and managed after-hour calls by allowing clients to send text messages to a personal cell phone. The client had a habit of texting the counselor when a life event triggered anxiety, and, on occasion, the texts would include statements containing suicidal ideation. The counselor discussed this with the client who explained that she used the texting capability to vent anger and that she had no plan or intent on harming herself. On the date of the incident, the client sent a text to the counselor stating that she wanted to die. The counselor interpreted this text as she had other similar ones in the past, as the client's expression of anger and dissatisfaction with her life circumstances. The counselor did not respond to this text, as she was at a social event and knew that the client had an upcoming appointment. Two days later, when the client did not keep the scheduled appointment, the counselor contacted the client's family who reported that the client died by suicide on the day that the text had been sent. Experts were critical of the counselor's failure to recognize the gravity of the expressed suicidal ideation and to notify law enforcement of the threat of self-harm immediately upon receiving the text. The total incurred for this claim was more than $200,000.

Telebehavioral Health

Telebehavioral health offers counselors an effective means of delivering services while increasing client access to care. However, working with clients in crisis through a virtual platform presents unique clinical, ethical, and safety challenges. Unlike in person care, clinicians must be prepared to assess and respond to imminent risk without physical proximity, relying instead on proactive planning, clear communication, informed consent and coordinated emergency response procedures. Establishing a comprehensive emergency plan before initiating telebehavioral services is essential to ensure client safety, support ethical decision making, and reduce risk in the event that a client experiences a crisis during a remote sessions.

Risk Control Recommendations:

The following recommendations are intended to support counselors in delivering safe, effective care and in reducing their exposure to professional liability claims when working with clients in crisis.

Crisis Intervention

- ***Utilize and document the use of evidence-based crisis intervention models*** through a trauma-informed lens during crisis assessment, intervention and stabilization.
- ***Consider the core tenets of Trauma-Informed Care*** promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA) during crisis counseling to prevent re-traumatization.

After-Hours Emergency Coverage

- ***Develop written formalized coverage policies for after-hours emergencies*** to ensure that emergencies are managed expeditiously. Ambiguous or inconsistent after-hours procedures can create professional liability exposure when emergency care is required for clients in crisis. Policies should be reviewed and updated periodically.
- ***Inform clients about methods of contact for urgent concerns*** during the initial counseling session, informed consent discussions and session reminders.
- ***Limit communication via texting to non-clinical content***, i.e. appointment confirmation, directions. Inform clients that texting after hours is not permitted as there may be a gap in response time. For awareness, communication of clinical advice via texting may be discoverable in the event of a professional liability claim.
- ***Avoid offering personal cell numbers to clients***, as this may blur boundaries and contribute to gaps in care during crisis situations.

Crisis Resources

- ***Provide clients with crisis-related resources, such as the 988 suicide and crisis lifeline, and confirm their understanding*** and willingness to utilize these resources in the event of a crisis or mental health emergency. Document the client's verbal acknowledgment of understanding.
- ***Ensure that clients have "Someone to contact, someone to respond and a Safe Place for Help"*** as outlined in the 2025 National Behavioral Health Crisis Care Guidance.

Confidentiality Limitations during Client Crises

- ***Develop a written policy outlining the process for release of confidential information.***
- ***Obtain client consent to contact and collaborate with other mental health professionals involved in their treatment*** to ensure that all members of the healthcare team are aware of any significant changes in the client's condition.

- ***Inform clients about situations in which confidentiality protections may not apply*** at the outset of counseling, such as when foreseeable harm to self/others is noted according to the 2014 ACA Code of Ethics, as well as state and federal statutes. Document these discussions and obtain signed statements that the client understands these exceptions to privacy and confidentiality protections.
- ***Practice within state-specific duty to protect/warn legislation*** and in compliance with standard of care and state licensing/certifying board requirements. If more than one standard of care, law or regulation is implicated, adhere to the most stringent applicable standard.

Suicide Risk Assessment

- ***Ask questions regarding suicidal ideation openly*** and ensure that the counseling plan aligns with the risk assessment findings. Conduct universal screening for suicide risk, regardless of presenting complaints, and conduct assessments at each client contact.
- ***Utilize an evidence-based suicide risk assessment tool*** and consider co-occurring issues that may increase the client's level of suicide risk, such as depression, substance use disorders and access to lethal means. Document the interpretation of findings.
- ***Ask client-centered suicide risk assessment questions.*** For example, when assessing older adults, ask questions specific to loneliness, bereavement and physical/cognitive decline and for young adults, include questions relating to bullying, social media and family dynamics.
- ***Consider risk factors, objective observations of behaviors and verbal/non-verbal communication*** when formulating a clinical interpretation of risk assessments.
- ***Assess client access to lethal means at every level of suicidality,*** as described in the National Action Alliance for Suicide Prevention's "Lethal Means & Suicide Prevention: A guide for Community & Industry Leaders". Work collaboratively with clients to limit access to lethal means and reassess access as needed.

Documentation

- ***Develop a standardized practice for documenting in the healthcare information record.*** As a complete and accurate clinical record presents the strongest defense in a PL claim, the following information should be documented, at a minimum:
  - The clinical decision-making process, as well as the client's diagnosis, treatment plan, response to treatment, results of diagnostic testing and/or consultation findings, suicide risk assessments and safety plans.
  - Education regarding the client's treatment agreement, as well as education regarding policies and procedures.
  - Session notes, including review and revision of problems and/or treatment plan, the client's response and any change in diagnosis.
  - Telephone encounters (including after-hours calls), documenting the name of the person contacted, advice provided, and actions taken.
  - Acknowledgement of test results, referrals, and consultations, including a description of subsequent actions taken.
  - Referrals for medical assessment and/or for the prescribing and monitoring of psycho-active medications.
  - Educational materials, resources, or references provided to the client.
  - The client's informed consent for proposed treatment and testing.
  - Signs of non-adherence to the agreed-upon treatment plan, including missed appointments, refusal to provide information, and rejection of treatment recommendations. Document all efforts to follow up with the client and efforts to educate the client about the risks of non-cooperation or non-participation with the agreed-upon treatment.
  - Discussions of privacy, confidentiality of personal information and possible exceptions to those protections.
  - Signed and dated consent forms for release of information, if necessary, to client-authorized parties, child welfare organizations in the case of suspected child abuse, law enforcement personnel if the client is deemed to be a risk to self or others, and a court of law in response to an official court order or subpoena.
  - Counseling of non-adherent clients and/or responsible parties regarding the risks resulting from their failure to adhere to medication and treatment regimens.

Treatment and Safety Plans

- ***Utilize safety planning templates collaboratively with clients*** to identify their individualized triggers, protective factors and coping strategies—creating the safety plan in the same session in which suicidal ideation is identified and confirming that the client is willing to use it in a crisis.
- ***Ensure that the treatment plan aligns with the risk assessment findings***, particularly for clients who are identified as a suicide risk.
- ***Include a discussion about the potential for impaired judgment and altered cognition*** in a crisis, as part of the safety planning process.

Telebehavioral Health

Considerations for an emergency plan

- ***Develop an emergency plan prior to the initial telebehavioral session***, particularly when working with clients who may be at risk for suicidal ideation or other types of crises.
- ***Review the emergency plan with the client as part of informed consent*** for telebehavioral health and periodically thereafter.

- ***Explain the limitations of telebehavioral counseling in crisis situations*** and the circumstances under which emergency services may be contacted without prior consent.
- ***Contact emergency services on a separate phone or device while maintaining video connection***, in the event of an emergency. Provide the dispatcher with client's reported address and relevant clinical history.
- ***Document the following information in the client healthcare information record*** in compliance with federal privacy and confidentiality requirements:
  - The physical address where the client is located at the start of every telebehavioral visit, as patients may participate from different settings.
  - The name/ phone number of a local emergency contact, such as a family member or friend.
  - Contact information for other treating healthcare providers after confirming that they can assist if a crisis arises.
  - The patient's written authorization to release information to the emergency contacts listed and clarify the circumstances under which the counselor may contact this individual (e.g., imminent risk to safety).

Counseling clients in crisis requires a focused, individualized approach that ensures safety, reduces re-traumatization, and supports effective assessment and diagnosis. Counselors have a professional duty to ensure the safety and wellbeing of their clients.

For more information, you can read HPSO and CNA's full report, *Counselor Liability Claim Report: 3rd Edition*.
www.hpso.com/counselorclaimreport

HPSO

1100 Virginia Drive, Suite 250
Fort Washington, PA 19034
1.800.982.9491 www.hpso.com

CNA

333 South Wabash Avenue
Chicago, IL 60604
1.888.600.4776 www.cna.com

X-CN-SL-CiC-0726