Secure Connections LLC
A PSYCHOTHERAPY PRACTICE

CONFIDENTIALITY & ITS LIMITS

What is confidentiality?

In the context of therapy, confidentiality is the safeguarding of private information disclosed by a client to their healthcare provider. Basically, I cannot share what you tell me in therapy unless:

You want me to.

Most commonly, information is shared because you have given me permission to share it.

For example, many clients choose to use their health insurance benefits, which requires me to share certain protected health information (PHI) with their insurance company for billing and coverage purposes. You may also want me to coordinate care with a doctor, psychiatrist, former therapist, or another healthcare provider. Some clients choose to allow a partner or family member limited access — for example, allowing that person to schedule or verify an appointment.

Even if you sign a Release of Information (ROI), that does **not** automatically give the person listed on it access to everything you have told me or everything contained in your record. An ROI gives me permission to communicate within the limits *you* authorize; it does not give someone unrestricted access to your therapy.

Releasing information is your choice. If you wish to rescind access to a certain individual or entity you listed on your ROI, you may do so at any time through written or verbal communication.

I have reasonable cause to suspect abuse or neglect that I'm legally required to report.

As an LCSW, I am a mandated reporter under Arkansas law for suspected child maltreatment and certain forms of maltreatment involving endangered or impaired adults.

If I determine that a report is required, I will generally tell you, explain why, and discuss what information will be shared unless doing so could increase the risk of harm.

I also want to be clear about something important: I am very aware that involvement with DCFS can itself be frightening, disruptive, and in some cases, harmful to families. Families argue and parents become overwhelmed. Families may also be dealing with poverty, food insecurity, postpartum depression, substance use concerns, or other circumstances in which what they need most is meaningful support and access to services. I cannot promise that a report will always be avoidable, but I can promise to approach these situations thoughtfully, transparently, compassionately, and without treating every struggling family as though abuse or neglect is occurring.

There is an imminent danger of serious harm to you or someone else.

There are circumstances in which confidentiality may need to be broken to protect you or another person from an immediate and serious threat of harm. This does **not** mean that simply talking about suicide, self-harm, anger, violent thoughts, or disturbing thoughts automatically results in someone being called. **Context matters!!**

For example, saying, "I was so angry in that meeting last week I felt like I could have killed my boss," is very different from telling me that you intend to kill your boss, have developed a plan, have the means to carry it out, and intend to do so imminently.

The same principle applies to suicidal thoughts. Having suicidal thoughts does not, by itself, automatically mean hospitalization. My responsibility is to understand what is happening, assess the level of risk with you, and respond proportionately to the situation.

If I do have to involve another person or emergency service because of an immediate safety concern, I disclose only the information reasonably necessary to address that concern.

There is a medical emergency during session and you are unable to communicate for yourself.

If you experience an emergency and are incapacitated or otherwise unable to communicate, I may need to contact emergency medical personnel, an emergency contact, or another person involved in helping keep you safe.

Even then, confidentiality does not disappear. I share information based on what that person actually needs to do their job.

For example, an emergency contact may need to know what happened and where you are being taken. Paramedics may need your name, date of birth, known medications, allergies, or relevant medical history. They probably do not need to know about your childhood trauma, your relationship problems, or what you and I talked about three Tuesdays ago.

The goal is always the same: **share what is necessary for your care or safety — not your entire story.**

It is court ordered.

This is a rare occurrence. Ethically, it is my duty to fight subpoenas, because on their own, they do not automatically override privacy laws like HIPAA. However, court orders are directly signed by a judge and carries higher legal authority. Legally, there is nothing I can do to fight an order from a judge.

Any time subpoenas or court orders are received, you will be notified. If records are handed over in a court order, you will be provided a copy of all records shared.

MY CRISIS POLICY

Talking about suicide does not automatically mean going to the hospital. I want clients to talk honestly about suicidal thoughts without fear that I will lock them up.

There is a meaningful difference between: "I don't know how I can keep feeling like this for another few months" and "I don't know if I trust myself to stay safe right now." Both of those statements deserve attention, but they do not necessarily require the same response.



If thoughts come up.

Risk is not determined by one symptom, one answer, or whether you have a plan. I look at the whole picture, including how intense the thoughts or urges are, how able you feel to stay safe, what coping skills are available, who is around you, how much you trust those people, and whether they are actually able to help.

Because of that, two people with similar symptoms may need very different levels of support. Someone with moderate symptoms but very little trusted support may require more resources than someone with similar symptoms who has several reliable people actively helping them stay safe.

Level of Concern	What This Might Look Like	What We May Do Together
Lower Concern	Thoughts may be passive, fleeting, or without a current intention to act. You feel reasonably able to keep yourself safe, and there are coping strategies and/or trusted supports available if things become harder.	Review your safety plan; identify supports; address what may be contributing to the thoughts; coordinate with medication management when appropriate; continue monitoring together.
Increasing Concern	Thoughts or urges are becoming more frequent, intense, or difficult to manage; coping is getting harder; or the support around you is limited, unavailable, unreliable, or does not feel safe enough to depend on. Safety can still reasonably be maintained outside the hospital, but more support may be needed.	Strengthen the safety plan; involve trusted support people with your permission when possible; provide support-person education; reduce access to lethal means; increase psychotherapy contact when appropriate; coordinate promptly with other providers; increase crisis resources and check-ins.
High/ Immediate Concern	There may be significant intention to act, an actionable plan, access to lethal means, rapidly worsening symptoms, or an inability to develop a reasonable plan for immediate safety. This can also include situations where symptoms might otherwise appear moderate but there is not enough trusted, capable support to safely manage the situation outside a higher level of care.	We shift our focus to immediate safety. We will discuss urgent options together whenever possible. This may include mobile crisis services, emergency evaluation, or inpatient hospitalization when a less restrictive option cannot reasonably provide enough safety and support.

What about hospitalization?

I am aware that psychiatric hospitalization — especially hospitalization that someone did not choose — can be frightening, disempowering, and traumatic.

Hospitalization can temporarily reduce immediate access to suicide, but hospitalization itself is not complete suicide treatment, and the period immediately following discharge requires particular attention and continuity of care. Experts in suicide prevention recommend using less restrictive care when it can safely meet the person's needs and making hospitalization decisions collaboratively when the person is not in imminent danger.

If hospitalization become necessary, I try to extend as much power to my clients as possible. We can talk about:

Where you would prefer to go.

When there are reasonable options, I want your preferences considered.

Who you want involved.

We can discuss supportive people and what information they actually need.

What would make the experience less harmful.

If there are identity concerns, prior traumatic experiences, accessibility needs, medication concerns, or other information an emergency team should understand, we can identify those. I will advocate for you as much as I can.

If you come back and tell me the experience was awful, we can talk about that too.

You do not have to be grateful for being hospitalized. You may feel relieved; you may feel angry; you may feel safer; you may feel humiliated, frightened, violated, exhausted, misunderstood — or several of those things at the same time.

If harmful or discriminatory treatment occurred, you do not have to minimize it simply because someone believed they were acting in your best interest. We can talk about what happened. We can make room for how it affected you, and when appropriate I can help you identify ways to address concerns about the care you received.