Ethics in Public Mental Health

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Training Overview

- Table of contents
  - Framing Ethics
  - Ethical Practice as Process
  - Capacity to Make Treatment Decisions
  - As time permits: Substantial Risk Orders

- Aims
  - Underscore ethical practice is a process
  - Provide functional knowledge

Framing Ethics

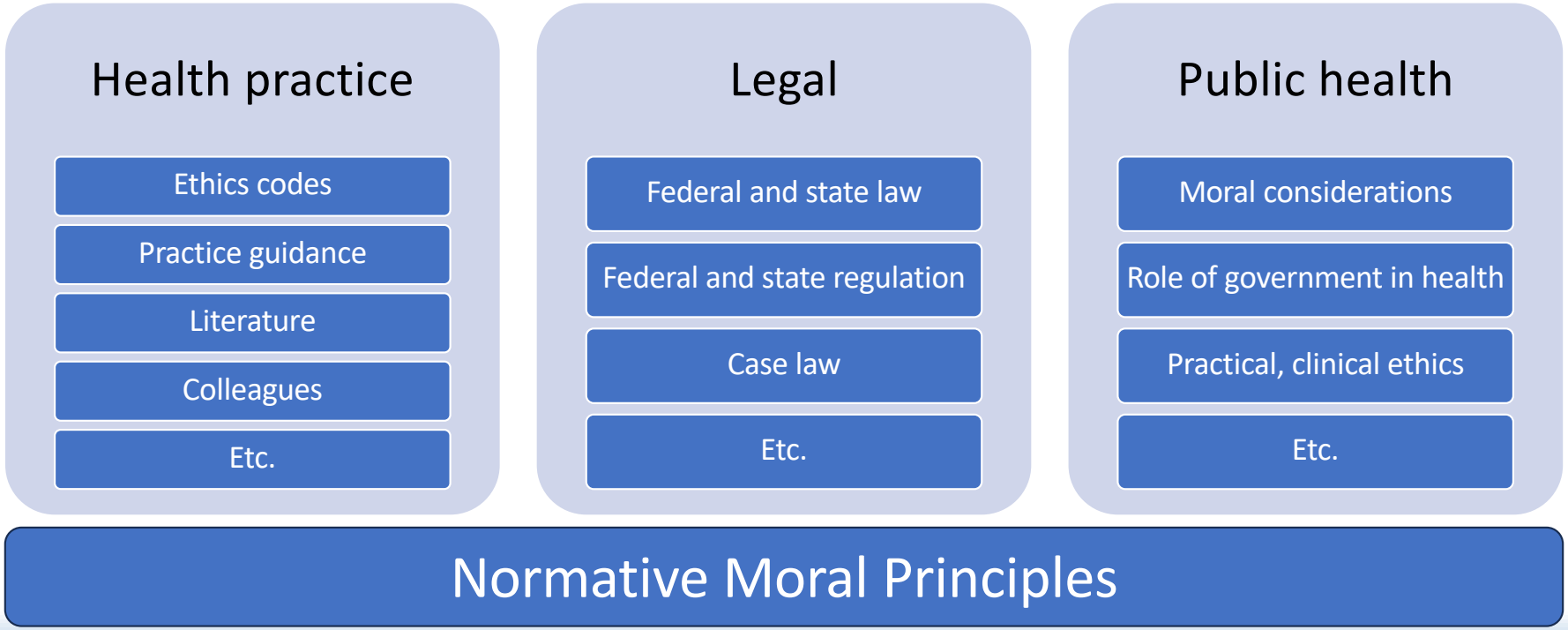
Importance of Ethical Practice and Policy

- Because Ethics.
  - Ways of understanding and examining moral life
  - Norms about right and wrong human conduct that are widely shared and therefore form stable social compact
    - Standards of conduct like moral principles, rules, ideals, and rights

- Not just about compliance; ethics can enrich and improve practice and policy
  - e.g., Fair, transparent deliberative policy process

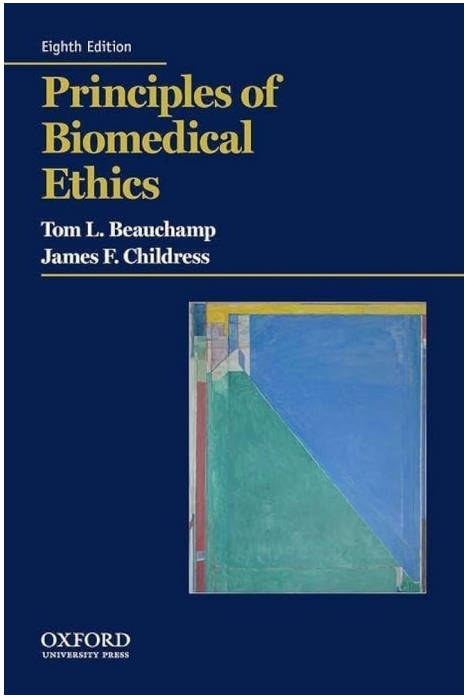
- Distilled from the abstract into the concrete in many ways
  - e.g., Professions have professional morality with standards of conduct that are acknowledged and encouraged by those in the profession → Standards of practice

Ways to Frame (and Sources of) Ethical Guidance in Mental Health Practice



Core Biomedical Ethical Principles

- Respect for autonomy
  - Moral decision-making assumes rational agents making informed, voluntary decisions
- Non-maleficence
  - Do not intentionally cause harm, through commission or omission; standard of care that avoids or minimizes harm
- Beneficence
  - Duty to be of benefit, and to take steps to prevent and remove harm
- Justice
  - Fairness, fair distribution of goods, distributive justice



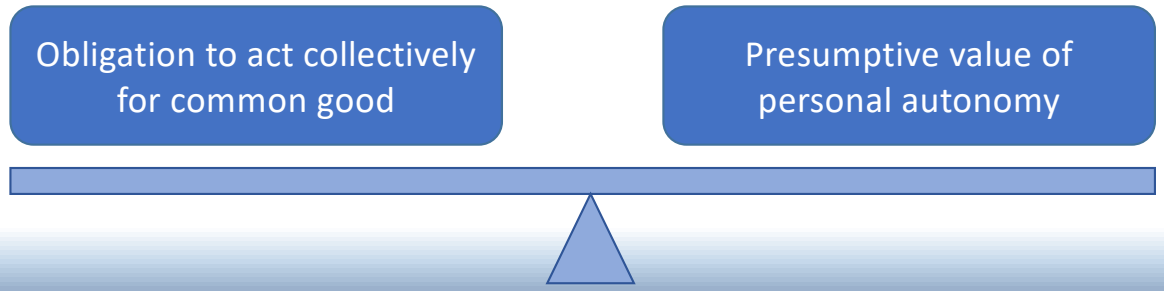
Public Health Ethics

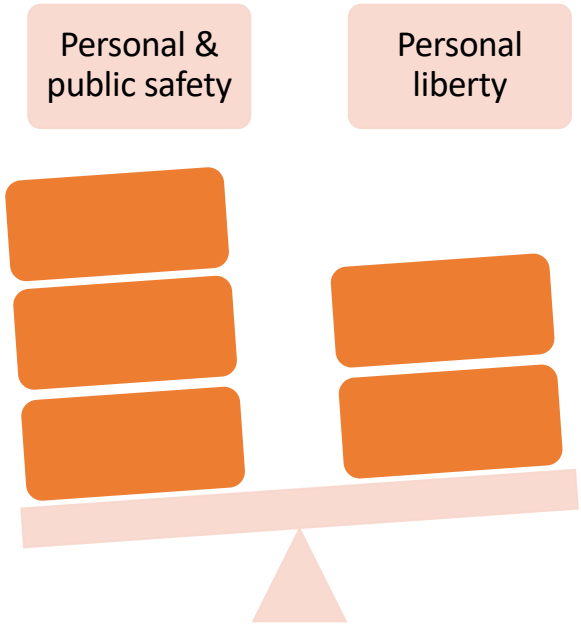
- Less about right vs. wrong, more about assessing the collective ethical valuation
  - Which ethical values are involved, how they are prioritized by stakeholders, whether there is consensus

> "[B]ecause ethical decision making depends on context (e.g., on local circumstances, community stakeholders, and decision makers), no formula can determine the most relevant ethical principles."
>
> - Ortmann et al., 2016, p. 13

Ethics with a Community/Population Focus

- Public health ethics
  - Can overlap with individual-focused clinical ethics
  - Key principles of beneficence, nonmaleficence, respect for persons, and justice just as foundational
    - But expanding scope of thinking to address public health interventions
  - Frameworks reflect counterbalance between:





Ethical Practice as Process

Ethical Practice is a Process

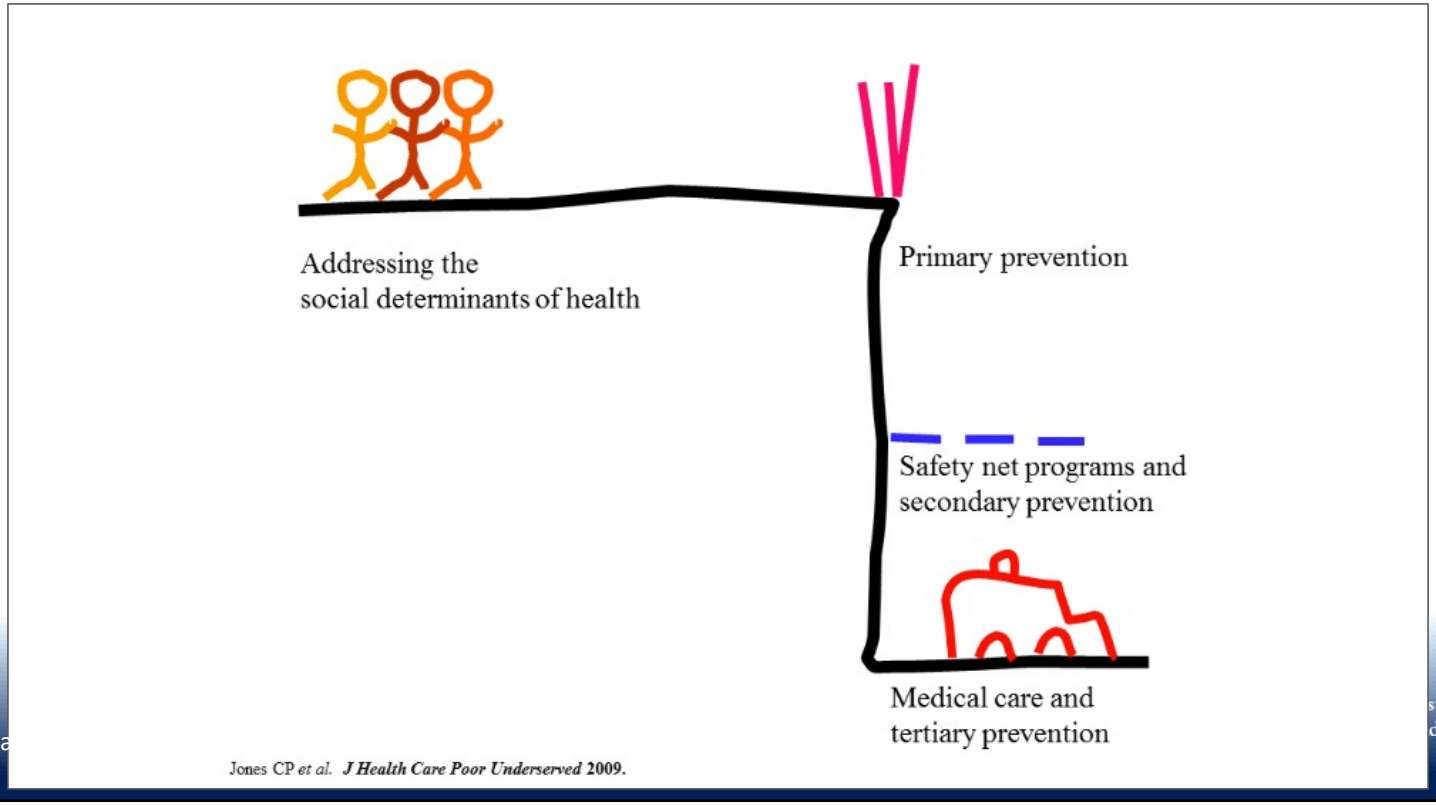
"Ethical decision making is a process. There are many instances in social work where simple answers are not available to resolve complex ethical issues."

-NASW Code of Ethics

- Ethics is not just about reaching an endpoint that is ethical, it is about the process and procedures followed to reach such decisions too.

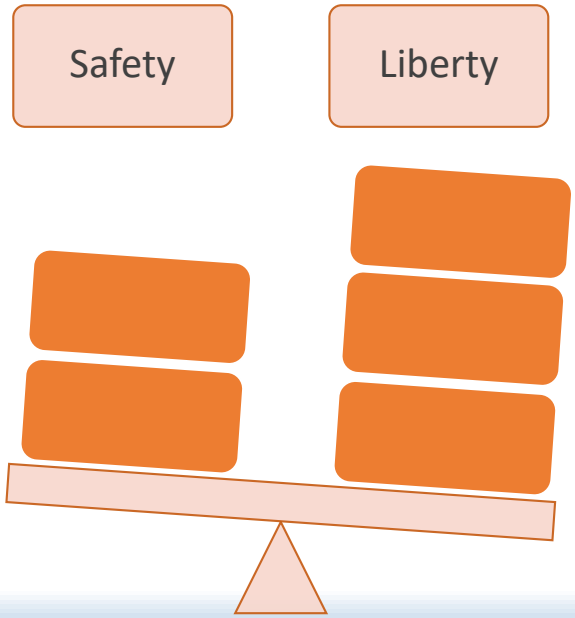
Ethical Practice is a Process

- "Preventive ethics" – the process can begin before a case arises



Applying Ethics Often Means Balancing Interests

- Besides extreme cases and defined rules, there are few set answers for many cases
- Values underlay all practice and policy
  - When defining a practice standard or making a policy choice, are presupposing a prioritization of values
  - When there is disagreement, likely has roots in differing prioritization
- Cases involve the conduct and interests of multiple people, groups, and/or authorities
- So, many issues and cases require balancing of interests that are at odds



Conflicts between Law and Ethics

- Balancing public and individual interests often the source for mismatches between ethics defined in professional ethics codes and ethics as promulgated in law

- Such conflicts are generally contemplated by ethics codes, e.g.,

[APA] 1.02 Conflicts Between Ethics and Law, Regulations, or Other Governing Legal Authority

If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.

[ACA] I.1.c. Conflicts Between Ethics and Laws

If ethical responsibilities conflict with the law, regulations, and/or other governing legal authority, counselors make known their commitment to the ACA Code of Ethics and take steps to resolve the conflict. If the conflict cannot be resolved using this approach, counselors, acting in the best interest of the client, may adhere to the requirements of the law, regulations, and/or other governing legal authority.

Common Conflict: Confidentiality and Safety

NASW

1.07 Privacy and Confidentiality

(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons…

ACA

B.1.c. Respect for Confidentiality

Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification.

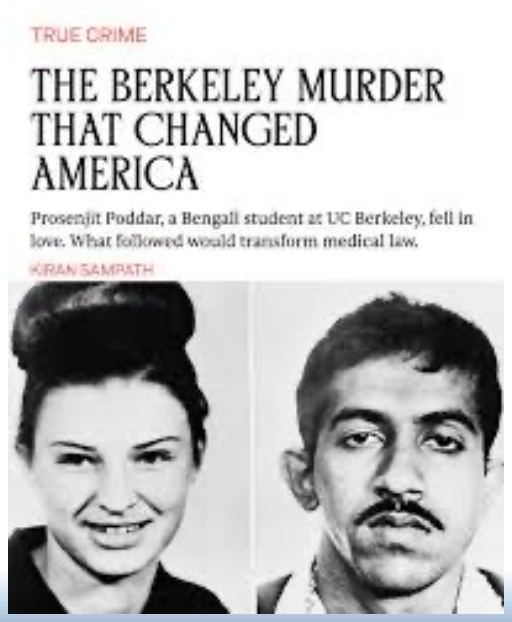
APA

4.01 Maintaining Confidentiality

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

Common Conflict: Confidentiality and Safety

"The protective privilege ends where the public peril begins"



Va Code § 54.1-2400.1. Mental health service providers; duty to protect third parties; immunity.

B. A mental health service provider has a duty to take precautions to protect third parties from violent behavior or other serious harm only when

- the client has orally, in writing, or via sign language, communicated to the provider
- a specific and immediate threat to cause serious bodily injury or death
- to an identified or readily identifiable person or persons,
- if the provider reasonably believes, or should believe according to the standards of his profession, that the client has the intent and ability to carry out that threat immediately or imminently.
- …
- The duty to protect does not attach unless the threat has been communicated to the provider by the threatening client while the provider is engaged in his professional duties.

Striking the Balance: Specifying the Extent

- Part of the balance struck includes defining expected extent of the duty/breach of confidentiality
- The duty…is discharged by a mental health service provider who takes one or more of these 6 actions:
  - Seek involuntary admission of the client (voluntary admission also removes the means of the threat)
  - Makes reasonable attempts to warn the potential victims
  - Makes reasonable efforts to notify a law-enforcement official having jurisdiction in the client's or potential victim's place of residence or place of work or both
  - Takes steps reasonably available to the provider to prevent the client from using physical violence or other means of harm until the law-enforcement agency can be summoned and takes custody of the client
  - Provides therapy or counseling to the client or patient in the session in which the threat has been communicated until the mental health service provider reasonably believes that the client no longer has the intent or the ability to carry out the threat
  - For a registered peer recovery specialist, or QMHP who is not otherwise licensed, reports immediately to a licensed mental health service provider to take one or more of the actions above

Striking the Balance: Limiting Civil Liability

- So long as the threat meets the criteria (specific, immediate threat of serious bodily injury/death of a readily identifiable person from a client with intent and ability to imminently carry it out) and you've taken one of the 6 steps to protect, then:

D. A mental health service provider shall not be held civilly liable to any person for:

- Breaching confidentiality with the limited purpose of protecting third parties by communicating the threats … made by his clients to potential third party victims or law-enforcement agencies or by taking any of the actions specified in subsection C.
- Failing to predict, in the absence of a threat…, that the client would cause the third party serious physical harm.
- Failing to take precautions other than those enumerated … to protect a potential third party victim from the client's violent behavior.

A Conflict Contemplated by Ethics Codes

NASW

1.07 Privacy and Confidentiality

(c)… The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or others. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

ACA

B.2.a Serious and Foreseeable Harm and Legal Requirements

The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed…

Public Health Ethics: 3-Step Framework

- Geared toward helping policy makers consider a policy in its context
- The framework is not designed to find what the 'right' option is
- Rather it helps determine what option(s) is most justifiable
  - Rarely can all ethical values, stakeholder norms and claims, be accommodated or equally prioritized
- Steps
  1. Assess the Issue
  2. Moral Considerations in Public Health
  3. Justificatory Conditions

The following slides summarize the steps as described across several resources:
Bernheim, R.G., P. Nieburg, and R.J. Bonnie (2007); Childress, J.R., R.R. Faden, R.D. Gaare, et al. (2002); Ortmann, et al. (2016).

1. Assess the Issue

- What public health problems, needs, concerns are at issue?
- What are appropriate public health goals in this context?
- What is the source and scope of legal authority, if any, and which laws and regulations are relevant?
- What are the relevant norms and claims of stakeholders in the situation and how strong or weighty are they?
- Are there relevant precedent legal and ethical cases?
- Which features of the social-cultural-historical context are relevant?
- Do professional codes of ethics provide guidance?

2. Moral Considerations in Public Health

- Producing benefits
- Avoiding, preventing, and removing harms
- Producing maximal balance of benefits over harms and other costs
- Distributing benefits and burdens fairly (distributive justice) and ensuring public participation including the participation of affected parties (procedural justice)
- Respecting autonomous choices and actions, including liberty of action
- Protecting privacy and confidentiality
- Keeping promises and commitments
- Disclosing information as well as speaking honestly and truthfully (a.k.a. transparency)
- Building and maintaining trust

3. Justificatory Conditions

- *Effectiveness*: Is the action likely to accomplish the public health goal?
- *Necessity*: Is the action necessary to override the conflicting ethical claims to achieve the public health goal?
- *Least infringement*: Is the action the least restrictive and least intrusive?
- *Proportionality*: Will the probable benefits of the action outweigh the infringed moral norms and any negative effects?
- *Impartiality*: Are all potentially affected stakeholders treated impartially?
- *Public justification*: Can public health officials offer public justification that citizens, and in particular those most affected, could find acceptable in principle?

Guidance for Public Health

"Ethical Action Guidance"

- "to inform and enlighten the judgment necessarily exercised by public health organizations and practitioners, not to eliminate the need for such judgment or to curtail reasonable and responsible discretion." - APHA Code of Ethics, p. 11
- Organized by domains of public health function
  - Conduct and disseminate assessments focused on population health status and public health issues facing the community
  - Investigate health problems and environmental public health hazards to protect the community
  - Inform and educate the public about health issues and functions
  - Engage with the community to identify and address health problems
  - Develop public health policies and plans
  - Enforce public health laws
  - Promote improved access to social resources conducive to health and health care
  - Maintain a competent public health workforce
  - Evaluate and continuously improve processes, programs, and interventions
  - Contribute to and apply the evidence base of public health
  - Maintain administrative and management capacity
  - Maintain capacity to engage with public health governing entities

Ethical Action Guidance: Example

Domain 3: Inform and educate the public about health issues and functions

Public health practitioners and organizations should strive to provide accessible information about public health issues and functions to the public, including but not limited to political leaders, health care providers, affected populations, and communities. Knowledge is a necessary (but insufficient) input into building healthy homes, workplaces, and communities. Imparting accurate and accessible information requires that public health practitioners and organizations use a variety of communication techniques and teaching methods, remaining sensitive to the diverse audiences they must reach. Doing so helps public health practitioners meet their goals of protecting the health and safety of individuals and fostering the health of communities.

Ethical policies and practices used to inform and educate the public about public health issues and functions should:

4.3.1. **Engage all members of the community.** Public health activities touch all members of a community, even those who do not recognize the work of the field. All members of a community should know or be made aware of how the efforts of public health practitioners and organizations help to keep them safe and healthy.

4.3.2. **Attend to the needs of diverse audiences.** Public health organizations serve individuals and communities that vary with respect to demographic characteristics, social and cultural factors, familiarity with public health, and health status. Ensuring that information and education about public health issues and functions are tailored to the needs of diverse audiences is critical to meeting the obligations of health and safety, justice and equity, and inclusivity.

4.3.3. **Be honest and accurate.** The design, implementation, and outcomes of some public health efforts are straightforward and extremely successful, while others are complex, debated, and uncertain. Public

Ethical Action Guidance: Example

- 4.3.2. Attend to the needs of diverse audiences. Public health organizations serve individuals and communities that vary with respect to demographic characteristics, social and cultural factors, familiarity with public health, and health status. Ensuring that information and education about public health issues and functions are tailored to the needs of diverse audiences is critical to meeting the obligations of health and safety, justice and equity, and inclusivity.

- Deaf and hard of hearing community
  - 37.5 million (15%) of U.S. adults ages 18+ have some trouble hearing
  - 1 in 8 people aged 12+ in the U.S. has hearing loss in both ears
  - Deaf individuals experience disproportionate lack of access to healthcare
  - Deaf and hard of hearing individuals experience exacerbated health disparities
  - Health literacy among deaf and hard of hearing individuals is low
  - The pandemic worsened access to healthcare – nearly 5 times more likely to have difficulty accessing information

Ethical Action Guidance: Example

Domain 4: Engage with the community to identify and address health problems

Public health practitioners and organizations should strive to create meaningful opportunities to involve members of the public in decision making and to build community partnerships that are based on mutual respect, co-learning, and shared power. These engagements and partnerships should seek to develop and implement policies and practices that improve population health and reduce health disparities; cultivate resilience, efficacy, and agency among individuals and communities; and promote accountability of and trust in public health institutions. Strong trusting partnerships can serve as a moral compass for routine public health planning and programming and in public health emergencies.

Ethical policies and practices used to engage with the community to identify and address health problems should:

4.4.1. Create meaningful opportunities for ongoing dialogue with stakeholder communities and the public at large to identify health challenges, opportunities, and priorities for action. Meaningful opportunities for dialogue provide people with factual and unbiased information communicated in plain language that the public understands, with adequate time to ask questions, express views, and receive feedback in an environment of mutual respect and reciprocity.

4.4.2. Encourage building public health capability early in life. Work should be done with schools, educators, parent groups, and others to provide improved health education to children. Health literacy in childhood and adolescence is a culturally and political sensitive topic in the United States, but constructive approaches can be developed with the help of educators and parents, among others. Many indicators of child health are alarming, and a life-span perspective indicates that many adult illnesses are affected by health experiences—both medical and psychosocial—early in life.

Ethical Action Guidance: Example

4.4.3. Be diligent in identifying communities and groups with a stake in health planning and programming activities. Inclusive efforts to identify and reach out to populations with a stake in health planning and programming and to reduce barriers to their participation are essential for public health success, especially including often omitted groups such as young and elder people. Such efforts need to extend beyond health care to other social sectors and involve both recognized community leaders and stakeholders without formal leadership positions.

4.4.4. Convene stakeholders throughout all phases of policy and intervention development, implementation, and evaluation. Inclusion of community members early and throughout health planning and programming can enrich team learning, improve the quality and relevance of health programs and interventions, identify and build community leadership, and strengthen community capacity and vitality.

4.4.5. Be responsive to community perspectives on health challenges, opportunities, and priorities for action. A responsive stance recognizes that communities living with health deficits are often best situated to understand the challenges to and opportunities for better health. Members of these communities have lived experience with social conditions that are detrimental to health and health conditions that can compromise well-being and agency. Ignoring community insights and experience can lead to ineffective programs and wasted resources and cause or compound public mistrust.

4.4.6. Be open to unanticipated ideas for creating positive change. Communities can be a rich source of creative ideas for health improvement, reflecting deeply situated knowledge of where and how people connect, share ideas, and influence positive change.

4.4.7. Be attuned to cultural, social, and historical contexts that influence community health and receptivity to public health partnerships. Attunement to cultural, social, and historical contexts is particularly important when addressing health disparities because communities burdened by excess

Ethical Action Guidance: Example

Nothing About Us Without Us in Policy Creation and Implementation

Jessica Isom, M.D., M.P.H., and Lilanthi Balasuriya, M.D., M.M.S.

This issue of *Psychiatric Services* includes the article "New Opportunities to Improve Mental Health Crisis Systems," which focuses on recommendations for federal, state, and local efforts to improve the U.S. system of care (1). Drs. Hogan and Goldman include a summary of actions intended to shift systems toward providing timely access to high-quality care for persons experiencing a mental health crisis. Evidence of renewed support for a nationwide infrastructure capable of supporting care across the continuum is also discussed. The authors make a compelling argument that the moment presents a ripe opportunity to advance policy goals in favor of an organized mental health crisis system.

Perhaps the most important policy-making ingredient for addressing meaningful access to high-quality and comprehensive crisis systems of care is the inclusion of patients' voices. As mental health professionals, we strive to practice patient-centered care in a collaborative manner, recognizing the importance of patients' voices and choices in our practice. As mental health advocates, we must similarly craft policies and redesign systems in ways that are responsive to

with a crisis team for fear of police violence and/
jail instead of to hospitalization. Second, the pe
specialist role represents a bridge between formal
care and community care and deserves stronger e
system redesigns.

We can draw inspiration from the use of psyc
vance directives and invite patients to state their
for treatment ahead of a crisis. These documen
support recovery but also provide an opportunit
that our patients' future treatment goals, particul
those in crisis, align with their wishes. Keeping th
the center means more than just words in a policy
or a patient-centered mission statement. The vision,
and values of the institution also must be alig
patient-centered approach, with the patient's vo
and community viewed as critical to treatment. C
collaborative, with patients and their families a
guiding the team toward the optimal crisis res
though these tenets may seem fundamental, the
missing despite being key to stakeholder engage

Perhaps the most important policy-making ingredient for addressing meaningful access to high-quality and comprehensive crisis systems of care is the inclusion of patients' voices. As mental health professionals, we strive to practice patient-centered care in a collaborative manner, recognizing the importance of patients' voices and choices in our practice. As mental health advocates, we must similarly craft policies and redesign systems in ways that are responsive to the perspectives and needs of those we serve. The empowering slogan "Nothing about us without us" captures a fundamental component of good policy making. Gaps identified across the continuum of crisis care represent opportunities to build the system of care from the ground up and craft a decision-making process that includes and welcomes those most affected by the system's successes and failures—people with lived and learned experiences.

Capacity to Make Treatment Decisions

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Core Biomedical Ethical Principles

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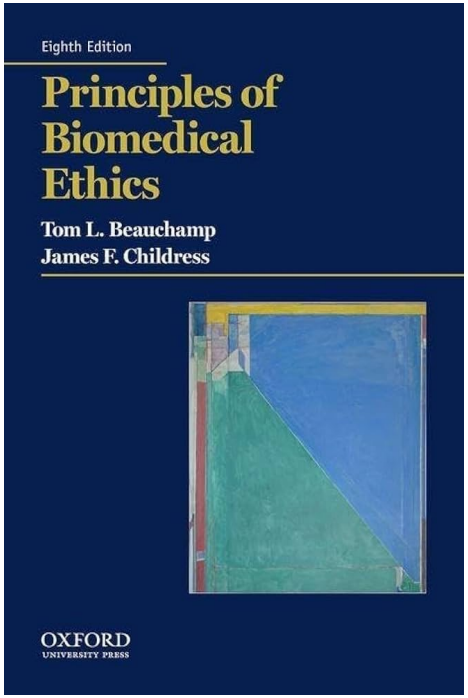
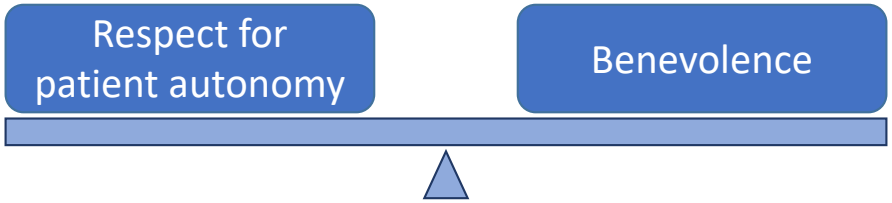


Bit of Ethics History

- Balancing risks and benefits to research subjects – cornerstone of research ethics since 1940s
  - 1932 – US Public Health Service begins Tuskegee Untreated Syphilis Study
    - 1940s – penicillin becomes treatment of choice and is widely available; not offered to men in study
  - 1947 – Nuremberg Code
  - 1964 – Declaration of Helsinki – World Medical Association
    - 1964 – proxy consent for people with diminished capacity
    - 1975 – review of research by an independent committee (a.k.a. ethics review committee, institutional review board)
  - 1972 – USPHS Tuskegee Study comes to light
  - 1978 – Belmont Report – National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research
  - HIV/AIDS pandemic – number of vaccine and drug trials increasing → use of ethics review committees increasing
  - 1991 – U.S. Dept. of Health and Human Service Common Rule
    - Governs review committess and human subjects research

Autonomy and Informed Consent

- Cornerstone of research ethics since 1940s = Balancing risks and benefits to research subjects
- Influenced clinical ethics and development of bioethics
  - Previously, paternalistic and focused on providing information and care based on physician's judgment
  - But respect for autonomy emphasizes right to receive information and make own decisions



Courts Tackle Informed Consent in Clinical Settings

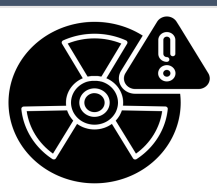
"What is the extent of a physician's duty to confide in his patient where the physician suggests or recommends a particular method of treatment?

What duty is there upon him to explain the nature and probable consequences of that treatment to the patient?

To what extent should he disclose the existence and nature of the risks inherent in the treatment?"

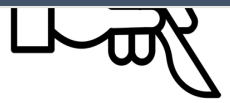
-Natanson v. Kline, 1960 (p. 403)

Clinical Informed Consent Case Law



Natanson v. Kline (Kan. Sup. Ct, 1960)

- Administered high doses of radiation to cancer patient without disclosing risks



Canterbury v. Spence (D.C. Ct of Appeals, 1972)

- Surgery without disclosing risk of paralysis

Zinermon v. Burch (Sup. Ct, 1990)

- Man admitted 'voluntarily' to psychiatric hospital despite significant symptoms

Courts Tackle Informed Consent in Clinical Settings

"[E]ach [person] is considered to be master of [their] of own body…"

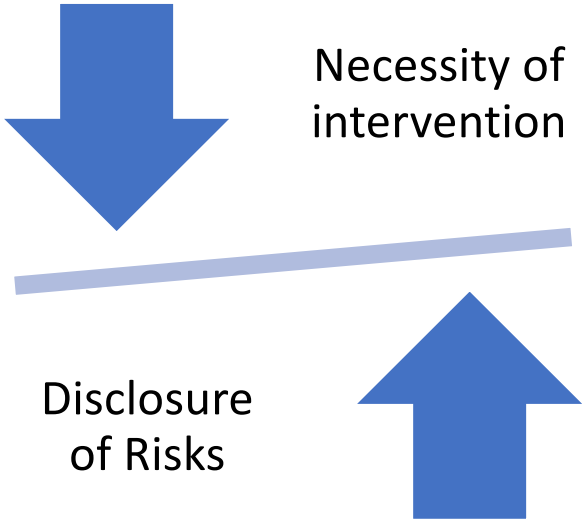
-Natanson v. Kline (p. 406)

"The root premise is the concept, fundamental in American jurisprudence, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."

-Canterbury v. Spence (p. 780)

Basic Principles of Informed Consent

- Nature of the procedure/intervention
- Risks and benefits
- Reasonable alternatives



Capacity and Informed Consent

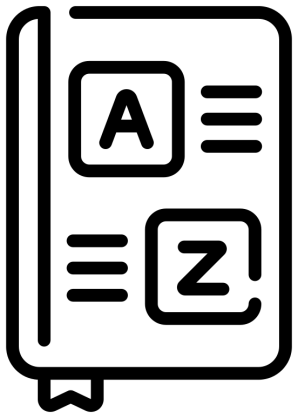
Capacity = the ability to make an informed decision about providing, continuing or withholding healthcare treatment

Informed decision = a decision by someone who is able to understand the nature, extent and likely consequences of the proposed healthcare decision and who makes a rational evaluation of the risks and benefits of alternatives to that decision

Consent = the voluntary agreement of a person (or the person's agent or authorized representative) to specific treatment or services

A quick note about terminology

- *"Capacity"* and "*Competence"* are often used interchangeably
- There is no universally agreed upon distinction between them
- We will use the term "capacity" today



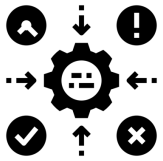
Capacity Defined

- The ability to make an informed decision about healthcare

- "Incapable of making informed decisions" =
  - The person is "unable to understand the nature, extent or probable consequences of the proposed health care decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision."

(Va. Code § 54.1-2982)

Capacity is Dynamic



Capacity is functional and contextual

Capacity to do what?

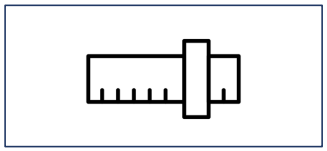
- It depends on the demands required of a particular decision, and the particular symptoms at issue

- Diagnosis ≠ capacity

Capacity is fluid

- It can change over time

Sliding Scale



- Seriousness of likely consequences of the decision will often affect capacity determinations

- Low Risk/High Benefit:
  - REFUSALS warrant more scrutiny
- High Risk/Low Benefit
  - DEMANDS warrant more scrutiny

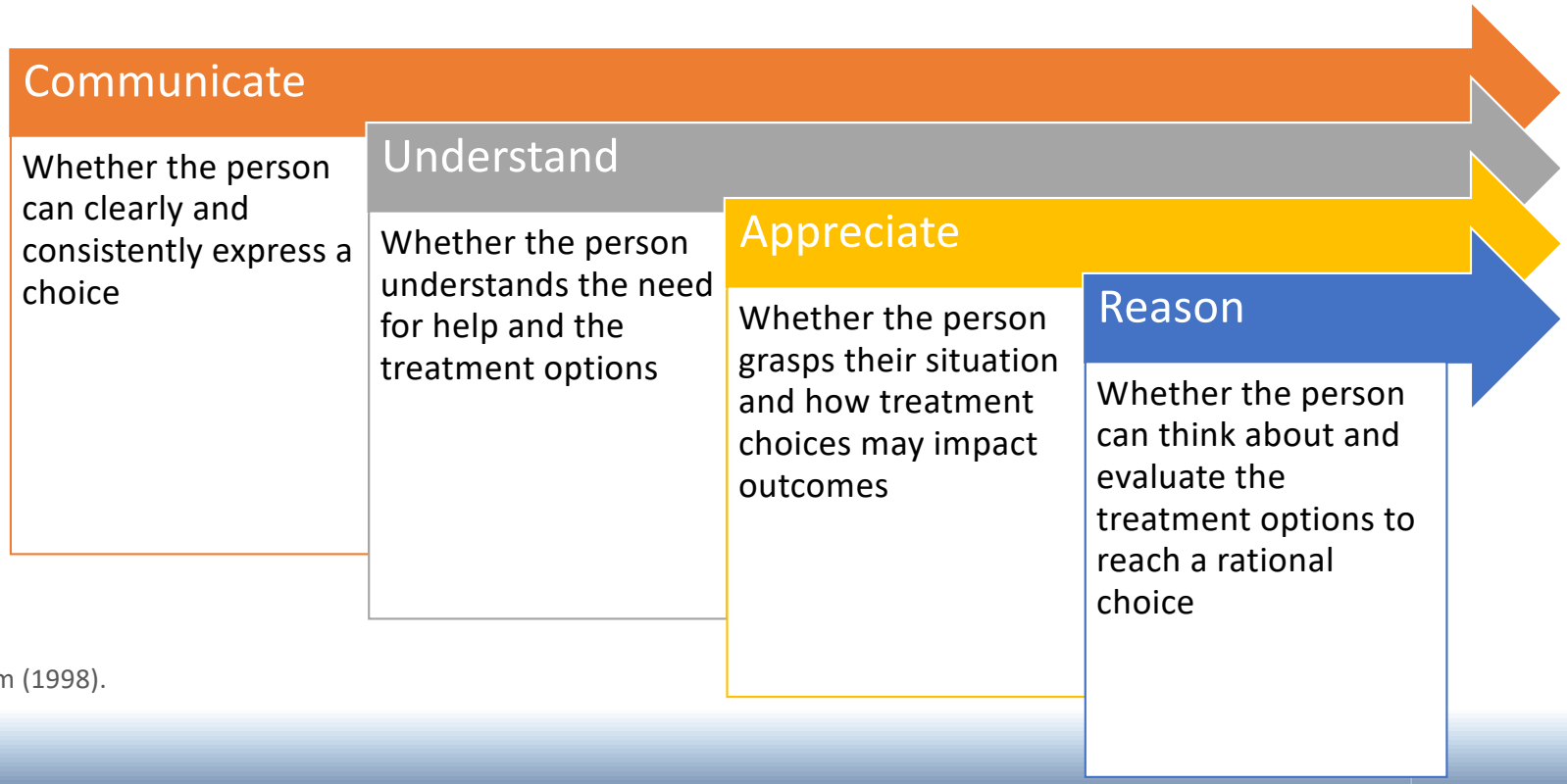
Va code § 54.1-2983.2(A)

Every adult shall be presumed to be capable of making an informed decision unless he is determined to be incapable of making an informed decision in accordance with this article.

A determination that a patient is incapable of making an informed decision may apply to a particular health care decision, to a specified set of health care decisions, or to all health care decisions.

No person shall be deemed incapable of making an informed decision based solely on a particular clinical diagnosis.

Capacity in a Nutshell



Grisso & Appelbaum (1998).

Assessing Capacity

Criterion	Clinical Approach
Communicate a choice	Ask the individual to express a choice about treatment
Understand relevant information	Ask the individual to paraphrase information about condition and treatment options
Appreciate the situation and its consequences	Ask the individual to describe their views of the condition, proposed treatment, likely outcomes
Reason about treatment options	Ask the individual to compare treatment options and consequences; offer specific reasons for the option they have selected

Appelbaum (2007)

Assessing Capacity

Criterion	Clinical Approach: *Sample Questions*
Communicate a choice	Have you decided to follow your doctor's recommendation for treatment? We've discussed some treatment options [perhaps briefly recap], what would you like to do? [If no decision]: What is making it hard for you to decide?
Understand relevant information	Tell me in our own words how the doctor described… - The problem with your health right now - Recommended treatment - Possible pros/cons of treatment
Appreciate the situation and its consequences	What do you believe is wrong with your health now? Do you believe you need treatment? What will treatment do for you? What will happen if you are not treated?
Reason about treatment options	How did you decide [X or Y treatment, reject treatment]? What makes [X] better than [Y]?

Appelbaum (2007)

Assessing Capacity

Criterion	Red Flags/Considerations
Communicate a choice	Frequently changes their mind
Understand relevant information	Seems to lack basic comprehension of medical information
Appreciate the situation and its consequences	Lack of insight Active delusions
Reason about treatment options	Focus on ***how*** decisions are made, not what the decisions are (we all have the right to make *unreasonable* choices, not *irrational* choices)

Appelbaum (2007)

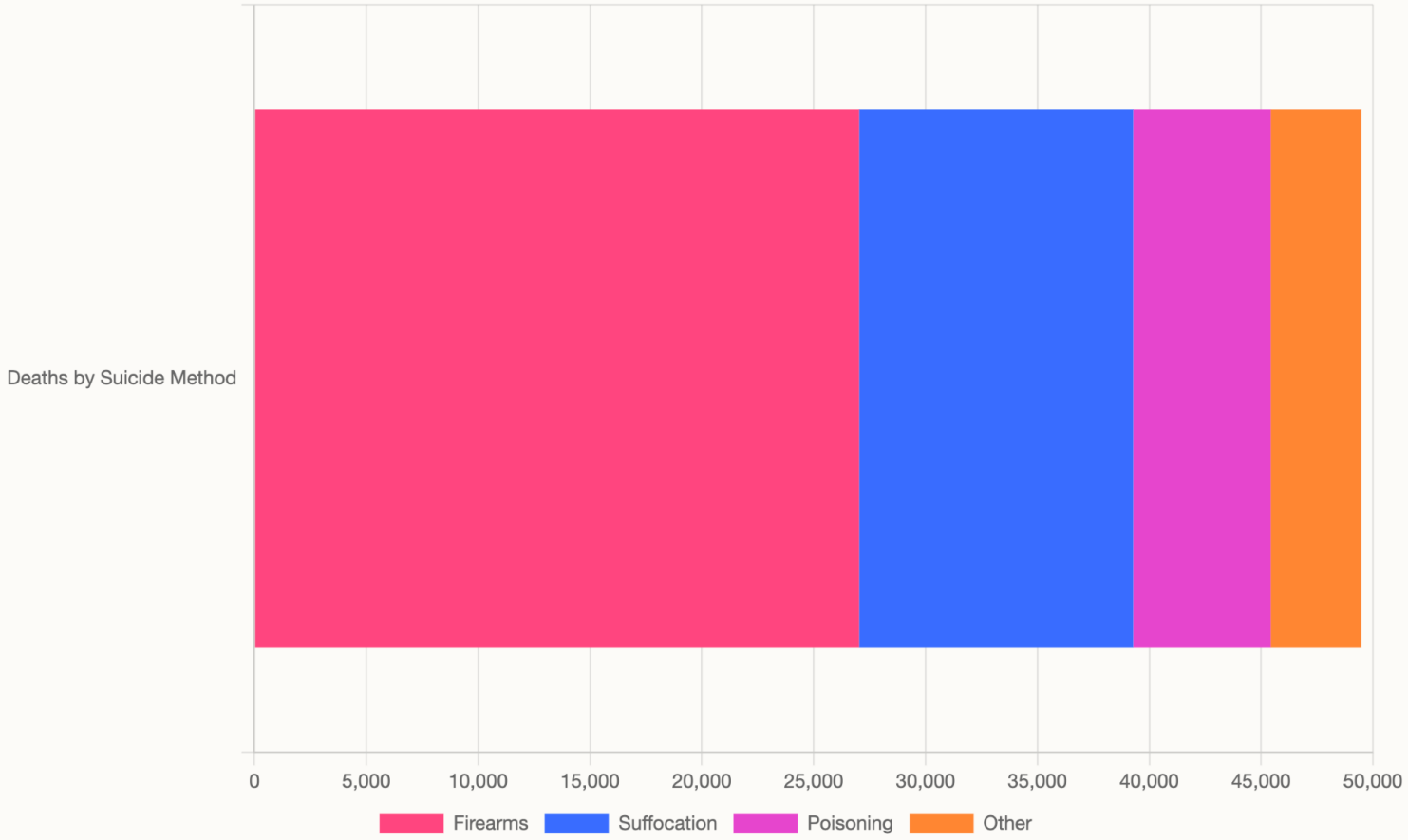
Alternative Legal Tools

Substantial Risk Orders

University of Virginia
Institute of Law, Psychiatry, and Public Policy

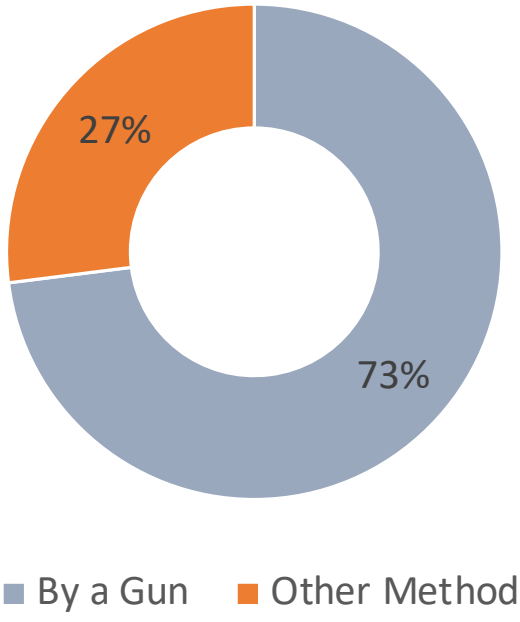
Suicide methods

In 2022, firearms were the most common method of death by suicide, accounting for a little more than half (54.64%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 24.75% and poisoning (including drug overdose) at 12.43%.

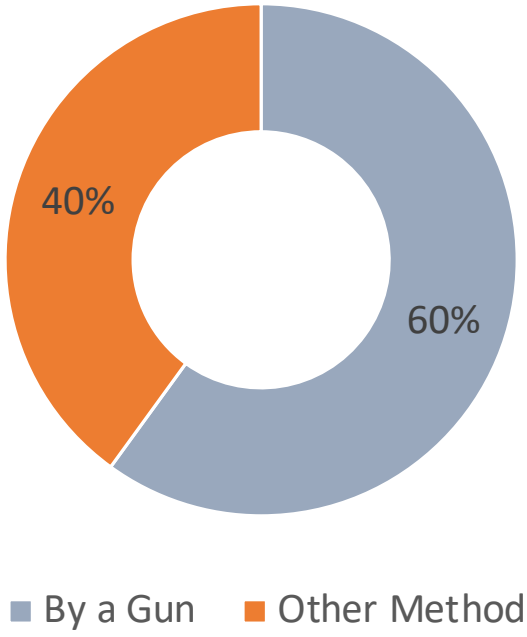


https://afsp.org/suicide-statistics/

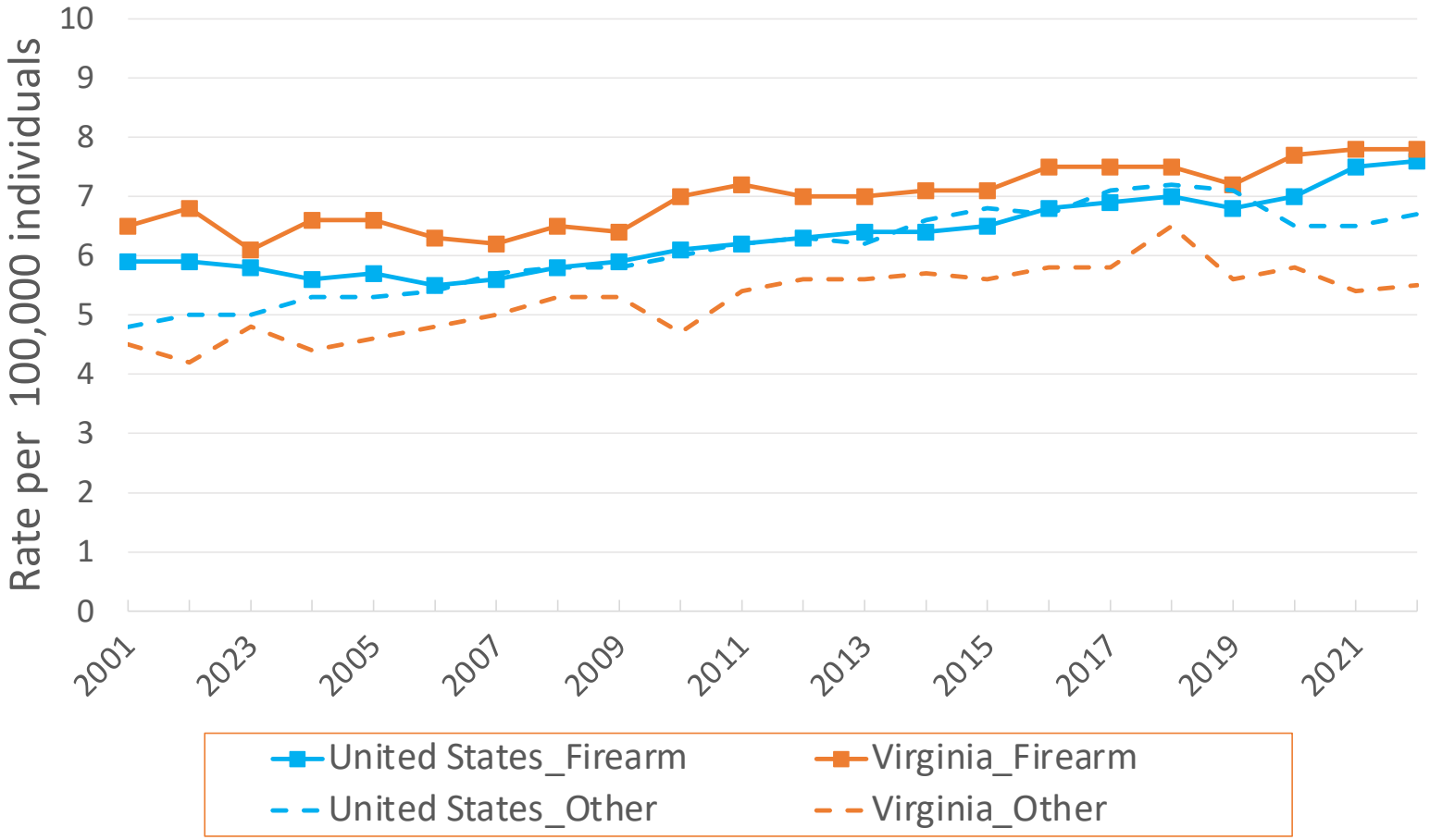
% of Homicides in Virginia



% of Suicides in Virginia



Sources: Centers for Disease Control and Prevention. National Center for Health Statistics. Underlying Cause of Death. Age-adjusted Gun Deaths and Rates per 100,000. WONDER Online Database, 1999-2022; & WISQARS. National Violent Death Reporting System (NVDRS) and Cost of Injury Modules. 2021-2022


Rate per 100,000 individuals
10
9
8
7
6
5
4
3
2
1
0
2001
2023
2005
2007
2009
2011
2013
2015
2017
2019
2021
United States_Firearm
Virginia_Firearm
United States_Other
Virginia_Other

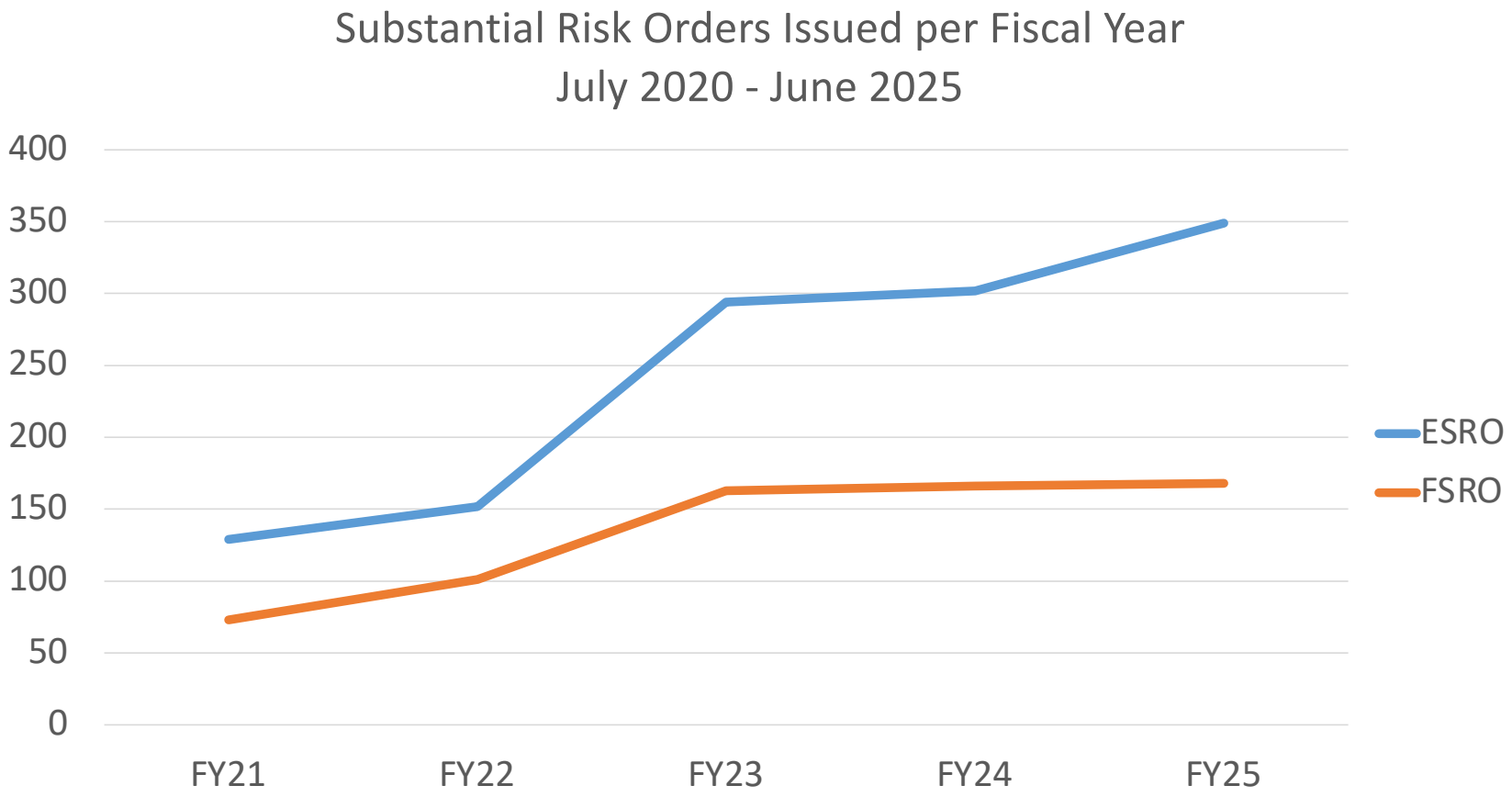
Extreme Risk Protection Orders

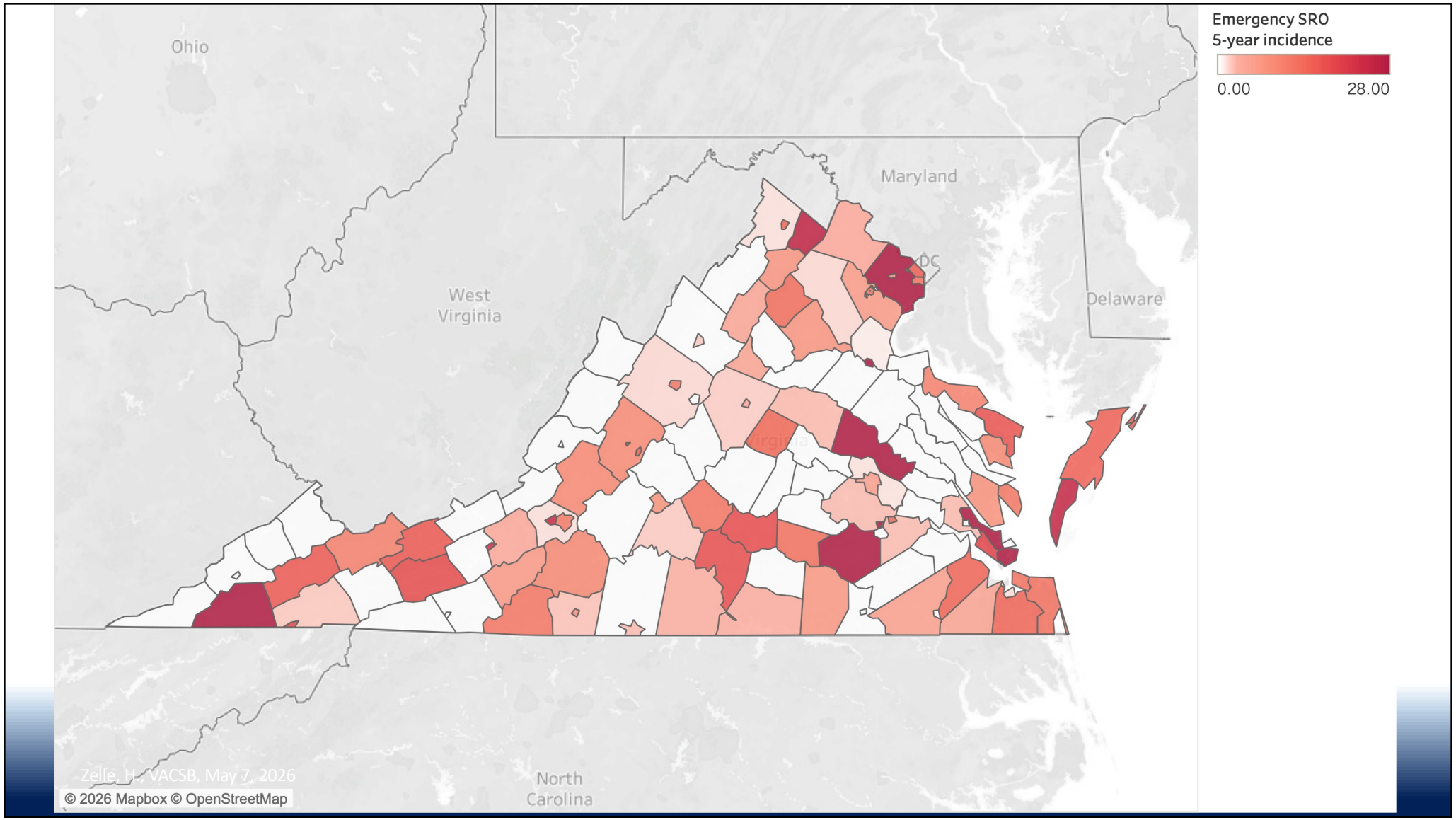
- Other terms:
  - Gun Violence Restraining Orders
  - Firearms Restraining Orders
  - Lethal Violence Protective Orders
  - “Red Flag Laws”

- Virginia terminology: Substantial Risk Orders
  - Emergency Substantial Risk Orders
  - Substantial Risk Orders

Extreme Risk Protection Orders

- Civil court order
- Authorizes temporary removal of firearms
- Mental illness is not a criterion
- Due process required
  - Hearing, time-limited removal, appeal process


Substantial Risk Orders Issued per Fiscal Year
July 2020 - June 2025
400
350
300
250
200
150
100
50
0
FY21
FY22
FY23
FY24
FY25
ESRO
FSRO


Emergency SRO
5-year incidence
0.00
28.00
Ohio
Maryland
DC
West
Virginia
Delaware
North
Carolina
Zelle, H; VACSB, May 7, 2026
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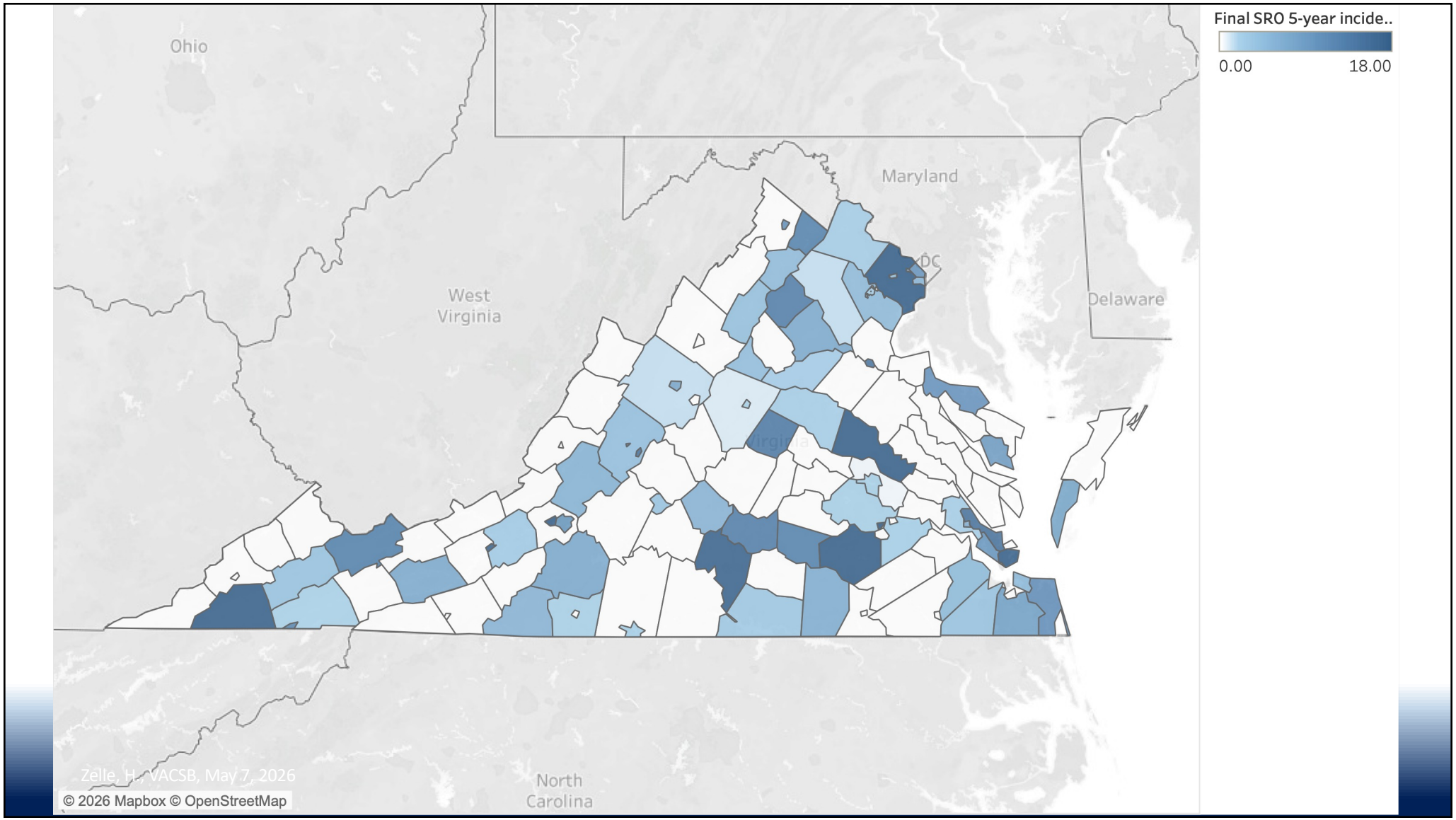
Final SRO 5-year incide..
0.00
18.00
Ohio
Maryland
DC
West Virginia
Delaware
North Carolina
Zelle, H., VACSB, May 7, 2026
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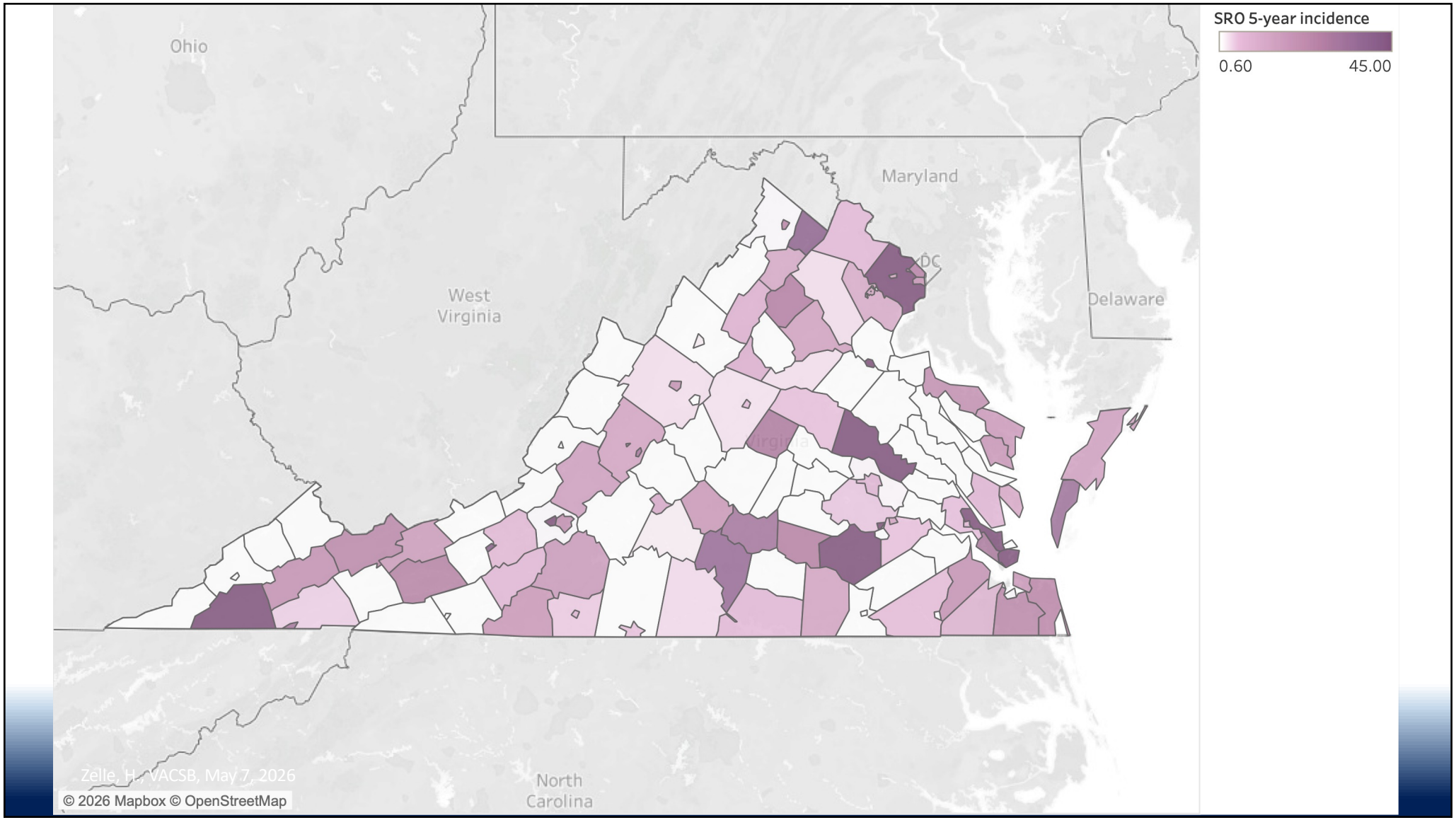

SRO 5-year incidence
0.60
45.00
Ohio
Maryland
DC
West Virginia
Delaware
North Carolina
Zelle, H., VACSB, May 7, 2026
© 2026 Mapbox © OpenStreetMap

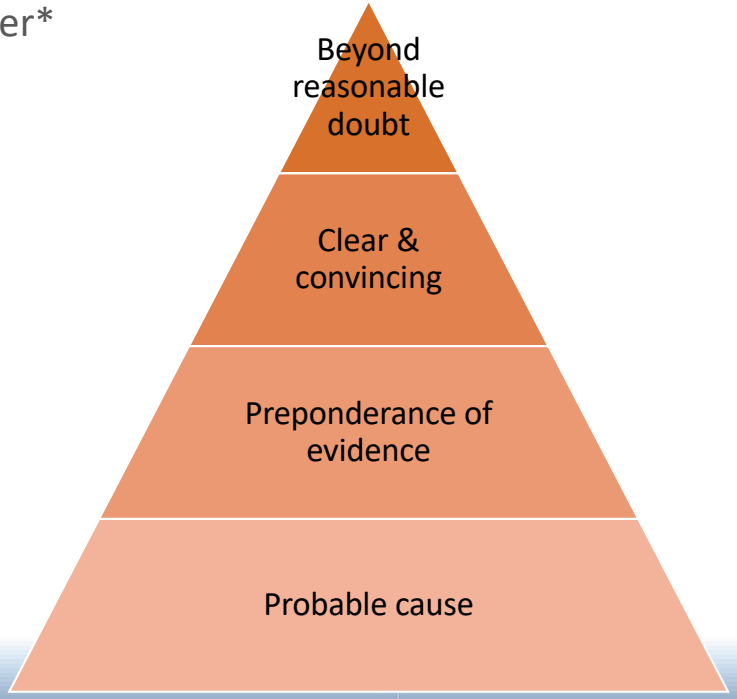
Virginia's Substantial Risk Orders

- SB 240 (2020)
  - Added to Title 19.2. Criminal Procedure:
    - § 19.2-152.13. Emergency substantial risk orders
    - § 19.2-152.14. Substantial risk orders
    - § 19.2-152.15. Return or disposal of firearms
    - § 19.2-152.16. False statement to law-enforcement officer, etc.; penalty
    - § 19.2-152.17. Immunity of law-enforcement officers, etc.; chapter not exclusive

Emergency Substantial Risk Orders

- Petition by Commonwealth's Attorney or a law-enforcement officer*
- Circuit court, general district court, J&DR court, or magistrate
- Ex parte

- Probable cause to believe that a person
  - poses a substantial risk of personal injury to
  - himself or others
  - in the near future
  - by such person's possession or acquisition of a firearm



Emergency Substantial Risk Order

House Bill 901
Senate Bill 495

- Effective July 1, 2026, people who can petition will include:
  - licensed professional counselor,
  - licensed clinical social worker,
  - licensed marriage and family therapist,
  - licensed clinical psychologist,
  - licensed clinical psychiatrist,
  - licensed psychiatric nurse practitioner,
  - psychiatric physician assistant,
  - psychiatric clinical nurse specialist,
  - doctor of medicine, doctor of osteopathy,
  - certified evaluator, designee of the local community services board,
  - immediate family or household member, intimate partner,
  - school administrator, or superintendent or superintendent's designee, who may be a representative from the threat assessment team established pursuant to § 22.1-79.4, of any school in which the person against whom the order is sought is currently enrolled or has been enrolled in the six months preceding the filing of such petition

Emergency Substantial Risk Order (cont.)

- In determining probable cause court shall:
  - consider any relevant evidence, including any recent act of violence, force, or threat …by such person directed toward another person or toward himself.*
- Upon finding probable cause, court shall issue an ex parte emergency substantial risk order

- No petition shall be filed unless an independent investigation has been conducted by law enforcement that determines that grounds for the petition exist.**

*Change effective July 1, 2026 (see next slide)

** As of July 1, 2026, the independent investigation requirement will be removed.

Emergency Substantial Risk Order (cont.)

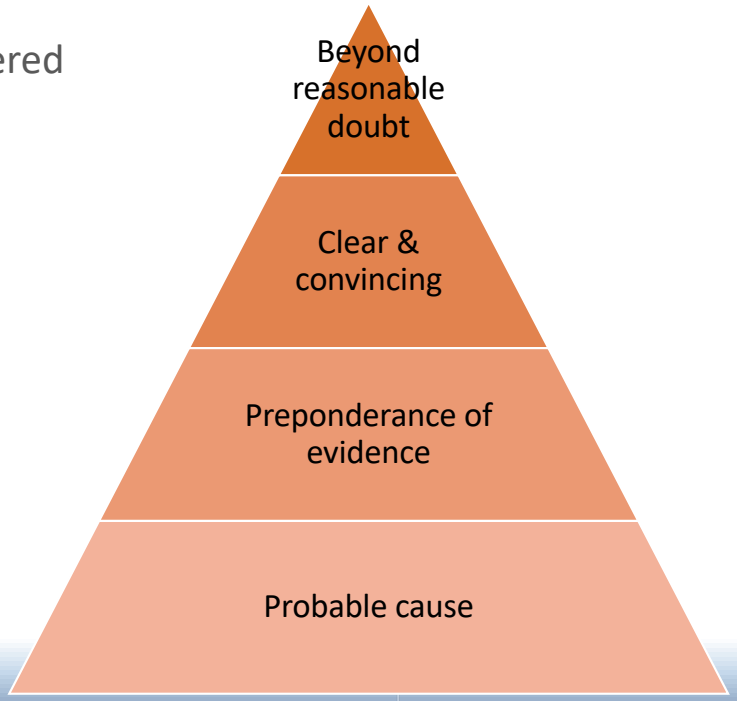
- As of July 1, 2026, relevant evidence for court's consideration will include:
  1. Any recent act of violence, force, or threat by such person directed toward another person, himself, a group of persons, or a location;
  2. Any recent act of violence, force, or threat by the subject of the petition toward an animal;
  3. Any recent violation of any provision of a protective order…;
  4. Any order entered pursuant to [adult involuntary hospitalization code];
  5. Evidence of recent or ongoing abuse of controlled substances or alcohol; or
  6. Evidence of recent acquisition or attempted acquisition of firearms, ammunition, or deadly weapons.

Emergency Substantial Risk Order (cont.)

- Order prohibits person from purchasing, possessing, transporting a firearm
- Effective upon personal service; shall be served forthwith after issuance
- Order expires at 11:59 p.m. on the 14th day following issuance of the order
- Person may file a motion to dissolve the order with the circuit court

Substantial Risk Order

- Circuit court hearing within 14 days of emergency SRO
  - To determine whether a substantial risk order should be entered
  - Person given notice of hearing
- Commonwealth's Attorney represents the interests of the Commonwealth
- Clear and convincing evidence that the person
  - poses a substantial risk of personal injury to
  - himself or others
  - in the near future
  - by such person's possession or acquisition of a firearm



Substantial Risk Order (cont.)

- If court finds clear and convincing evidence, shall issue a substantial risk order
- In determining clear and convincing evidence, court shall consider relevant evidence including that described in the Emergency SRO section

- SRO may be issued for a specified period of time up to a maximum of 180 days
  - Person may file a motion to dissolve the order one time during the duration of the order (motion may not be filed earlier than 30 days from issuance)
- Commonwealth's Attorney or a law-enforcement officer may file a written motion requesting a hearing to extend the order

Substantial Risk Order (cont.)

- If voluntarily relinquished firearms, may at this time transfer to another person aged 21 or older who is not prohibited by possessing firearms
  - Person and transferee must appear at hearing,
  - Law enforcement determined transferee not prohibited from possessing or transporting
  - Transferee does not reside with person
  - Court informs transferee of requirements and penalties
  - Court approves transfer subject to restrictions it deems necessary

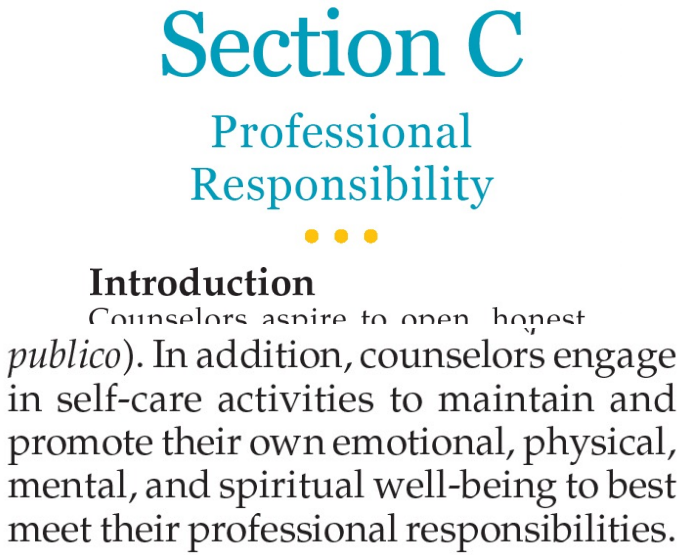
Substantial Risk Order (cont.)

- As of July 1, 2026, added provision about how to handle situations where the firearms lawfully belong to another person
- Firearm(s) returned to that person, provided:
  1. Firearm removed from respondent's custody, control, or possession and the lawful owner writes to court verifying how they will safely store firearm so respondent does not have access to firearm;
  2. Court advises lawful owner of potential penalties for violating code section about selling or providing illegal weapon; and
  3. Firearm is not otherwise unlawfully possessed by the owner.

In Closing

Self-Care as an Ethical Practice

- ACA Code of Ethics Section C. Professional Responsibility
- See also, e.g.,
  - APA Code 2.06 Personal Problems and Conflicts
  - NASW Code 4.05 Impairment



Section C

Professional Responsibility

Introduction

Counselors aspire to open, honest

publico). In addition, counselors engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.

Thank you!

zelle@virginia.edu

www.ILPPP.org

www.UVaMentalHealthPolicy.org

www.VirginiaAdvanceDirectives.org