Liability and Patient Suicide

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Suicide is one of the leading causes of liability against a psychiatrist treating adult patients. Reducing the risk of liability entails understanding the phenomenology of suicide, approaching suicide risk assessment from a clinical perspective, conceptualizing how malpractice cases unfold, examining the issues of foreseeability and proper risk assessment, and developing a risk management approach to mitigate against the potential for a bad outcome. The use of various suicide screening risk assessments in certain clinical contexts is a potentially useful first step in identifying the need for further risk assessment. In conducting a more detailed review of a patient's risk, nonsuicidal self-injury is typically distinguished from suicidal intent and action, although morbidity and mortality can also be associated with any deliberate self-injury. Understanding the concepts of means reduction and risk management planning are essential elements to assist in helping reduce risk. Special attention to risk reduction related to firearms has received increased attention in recent years. Proper assessment, and documentation thereof in clinical records can assist in reducing liability. This article reviews these basic elements for the general practitioner of adult psychiatry related to suicide risk, assessment, and liability surrounding patient suicide.

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MALPRACTICE CASE ARCHITECTURE

In cases of liability against psychiatrists, a suicide of a patient can be a common trigger for litigation. Generally, for a case to be decided for the plaintiff, several elements must be established. A common mnemonic that is used is the "four Ds" of a malpractice tort: duty, dereliction, damages, and direct causation. Duty is defined by the establishment of a doctor–patient relationship (1). Dereliction of that duty must directly lead to the damages (i.e., the death of the patient). Others have used words such as duty, negligence, causation, and harm (2), which essentially mean the same thing. Clinicians who are less familiar with the legal landscape of suicide malpractice might wonder how the physician is responsible for the actions of the patient who took his or her own life. However, through the special relationship created by the doctor–patient contact, the physician is expected to have used his or her special knowledge to prevent the suicide by adequately assessing suicide risk and treating the underlying condition. In other instances, the legal issue might involve questions of a negligent discharge of a patient and failure to assess suicide risk before discharge. In other words, in a malpractice review the question might hinge on whether the physician had negligently or intentionally taken action that led to the harm or failed to take action to keep the patient from succumbing to the condition for which he or she was in treatment.

In some states, there might be a contributory negligence allowance that would take into account whether the patient was capable of following the doctor's instructions and, if so, whether the patient's actions contributed to the bad outcome (3). Regardless, for liability against a practitioner to prevail, there is also the condition that the suicide would have been foreseeable had the right knowledge been obtained (4). Since most suicides are planned rather than impulsive (4, 5), in clinical practice, the issue in liability management will typically rest, therefore, on whether the clinician properly assessed the risk that a suicide would occur (4).

EPIDEMIOLOGY AND PHENOMENOLOGY OF SUICIDE

Definitions of suicide and surrounding terms are important to distinguish. According to the National Institute of Mental Health, a suicide is "a death caused by self-directed injurious behavior with an intent to die," whereas a suicide attempt is "a non-fatal, self-directed, potentially injurious behavior with intent to die" and suicidal ideation "refers to thinking about, considering, or planning suicide" (6). According to the American Foundation of Suicide Prevention, 47,174 individuals in the United States died by suicide in 2017, and there were 1.4 million suicide attempts (7).

Data from the Centers for Disease Control and Prevention (CDC) from 2016 show several findings related to suicide, including the following: suicide was the second leading cause of death after unintentional injury for

individuals age 10 to 34, the fourth leading cause of death for individuals age 35 to 54, and within the top 10 leading causes of death for all age groups; the overall numbers have been increasing at least since 1999 (8); there are far more attempts than there are suicides, with females attempting suicides more often than males and males completing suicide more often than females; Native American/Alaska Native and white males are the groups with the highest suicide rates; for women, the rates of suicide are highest between ages 45 and 54, and for men, the rates are highest for men over 65. Finally, overall, firearms, suffocation, and poisoning are the three leading means of suicide. In fact, firearms-related suicide accounts for nearly 50% of all suicides.

Data collected in the National Survey of Drug Use and Health (NSDUH) from 2018 showed that just over 4% of the adult population over the age of 18 had thought seriously about suicide over the past year and that among the total group, the group of persons with the highest percentage (11%) indicating positive responses to questions of whether they had serious thoughts of suicide were those 18 to 25 years of age (9).

NONSUICIDAL SELF-INJURY

Nonsuicidal self-injury (NSSI) can be mistaken for suicidal ideation and attempts. From a liability standpoint, it is important to understand these distinctions but also to recognize that individuals engaging in NSSI can die through their actions. In cases in which this occurs, and where there is litigation, there will still be a review of whether the risks of suicide and self-harm were appropriately assessed and managed. NSSI is often described as prevalent among patients with borderline personality disorder and seen in adolescents (10), but it can also occur among patients without borderline personality disorder (11). Management of these behaviors includes efforts to understand their purpose and minimize the patient's frequency and intensity of self-injury. It should also involve ongoing risk assessment for actual risk of death due to such injury, even if unintentional.

RISK FACTORS FOR SUICIDE

It is important for psychiatric professionals to understand the risk factors for suicide as well as protective factors that mitigate the risk of a completed suicide. Individual variations and nuances will lead to the need for a careful weighing of these and a thorough clinical assessment related to mental health, substance use, and other clinical factors as well as the presence of suicidal ideation, intent, plans, and access to lethal means to determine the level of care needed. A sound clinical assessment must take into account knowledge of risk and protective factors. According to the CDC (12), which also endorsed a previous report by the U.S. Surgeon General (13), risk factors associated with suicide include the following: family history of suicide; family history of child maltreatment; previous suicide attempt(s); history of mental disorders, particularly clinical depression; history of alcohol and substance abuse; feelings of hopelessness; impulsive or aggressive tendencies; cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma); local epidemics of suicide; isolation, a feeling of being cut off from other people; barriers to accessing mental health treatment; loss (relational, social, work, or financial); physical illness; easy access to lethal methods; and unwillingness to seek help because of the stigma attached to mental health, substance use disorders, and suicidal thoughts.

The CDC reports from the U.S. Surgeon General delineate several potential protective factors that protect against the likelihood of a completed suicide. These protective factors include the following: effective clinical care for mental, physical, and substance use disorders; easy access to a variety of clinical interventions and support for help seeking; family and community support (connectedness); support from ongoing medical and mental health care relationships; skills in problem solving, conflict resolution, and nonviolent ways of handling disputes; and cultural and religious beliefs that discourage suicide and support instincts for self-preservation (12).

It is important to note that the presence of any one risk factor, or even a combination of risk factors, is not dispositive for suicide, just like the presence of protective factors will not guarantee that an individual will not die by suicide. Also, the risk and protective factors do not specifically align in a formulaic manner. For each clinical situation, they must be weighed and analyzed with clinical judgment based on the nuances of the patient's personal circumstances. Still, the practitioner should be familiar with them and consider them in patient assessments. Documentation of the consideration of these issues will help demonstrate the adequacy of the assessment, which is discussed further below.

ASSESSMENT OF SUICIDE RISK

Although risk and protective factors are important to understand, the work with a patient at risk for suicide is to first recognize the risk (or, from a liability management standpoint, to "foresee the suicide") and then to develop a strategy to mitigate the risk. This is why, in malpractice claims, the issue often turns on what was known or should have been known in terms of foreseeability, which typically leads to an analysis of whether the risk assessment was properly conducted or at least sufficient and reasonable in accordance with what other similarly situated reasonable practitioners would have done, even if not ideal.

Clinical practice guidelines for the assessment of suicide risk in patients are available and provide some guidance, such as the guide to the general psychiatric evaluation of adults (14) and a guideline that was written regarding the assessment of suicidal behaviors (15), both produced by the American Psychiatric Association (APA). Other guidelines for managing risk in specific populations are available, such as one focused on veterans (16). The guidelines can provide a

useful resource, although practitioners will find that not all situations and patient circumstances will be covered, and they do not dictate the standard of care across clinical scenarios.

Of course, in a clinical assessment, it is important to assess the specific issues related to psychiatric diagnoses and whether there are underlying treatable conditions such as depression, psychosis, and even posttraumatic stress disorder (PTSD). Taking into account unique aspects of an individual's background might shed further light on specific risk factors. For example, populations of individuals who may have unique risks and therefore benefit from some further nuanced assessments include transgender individuals (17), veterans and people with a history of military service (18), and older adults (19). Also, suicide risk factors can vary across settings such as inpatient and outpatient, correctional (20), or Veterans Administration sites, to name a few, where supports and the potential for monitoring will vary; hence, guidelines unique to these settings can be a useful tool for practitioners.

Although the full details of the guidelines are beyond the scope of this article, the APA's summary of "stop a suicide" has culled key variables to consider in assessing overall risk during the initial evaluations of psychiatric patients. The recommendations include further inquiry once current suicidal ideation is present. Areas for exploration include examining the patient's intent regarding suicide, especially if symptoms worsen; examining access to lethal means, including firearms (discussed later); inquiring into motivations for suicide (attention, revenge, shame, guilt, psychotic motivations, etc.); and assessing the patient's reasons for living, the quality of the relationship with the practitioner, and any history of suicide among biological relatives (14).

FIREARMS AND SUICIDE

Firearms present unique issues in the suicide risk assessment. Because national data suggest that almost half of suicides are completed with the use of a firearm (21), it is important to consider how best to approach risk identification with firearms. In addition to a sound clinical risk assessment, highlighting other areas such as impulsivity and substance use can be helpful in ascertaining risks. For example, firearm ownership and risky behaviors have been seen with alcohol misuse (22). There is a growing literature on how to approach patient suicide risk assessment related to firearm usage (15, 23).

In previous work, for example, recommendations have included a two-tiered risk assessment pertaining to firearms, which has relevance to both suicide risk and violence risk. Specifically, the level 1 inquiry consists of asking patients basic questions about firearm access, storage, and ammunition availability. The psychiatrist would also ask patients about social supports that might be helpful in ensuring that firearm access is limited for the patient, if necessary. If clinically indicated, the level 2, firearm-specific risk assessment entails a more detailed set of questions that help the clinician understand the patient's relationship to firearms (e.g., new interest, psychodynamic attachment to the firearm, peer and family views, etc.) and other factors that would yield information to develop a risk management plan (23).

As far as risk management goes, various approaches can be helpful with regard to suicidal ideation. One study suggested that, after a careful assessment, a multidisciplinary approach to risk reduction can be helpful for patients who had been hospitalized after expressing suicidal ideation related to use of firearms (24). One example of a patient-specific approach is using firearm restriction counseling, which was shown to be helpful in the case of combat veterans in treatment (25). Several states have recently passed laws related to gun violence restraining orders, or "red flag laws," which allow for the removal of a firearm from an individual who is thought by others (not necessarily clinicians) to be a risk of harm to themselves or others and for whom access to a firearm might present an elevated risk. Guidance on these laws is available through an APA resource document recently made available (26).

SCREENING AND ASSESSMENT FOR SUICIDE RISK

With the growing awareness of suicide on the rise, numerous public health efforts have been gaining traction, beyond suicide hotlines that are available nationwide. One such effort, for example, called Zero Suicide, approaches the idea that suicides within behavioral health and other health care settings are preventable. As such, the framework emphasizes that all efforts should be initiated to effectuate the prevention of suicides (27). This correlates to various other coalescing forces that support the use of appropriate screening for suicide, which can help point out "red flags" for risk that should catalyze further clinical assessment. Indeed, the concept of suicide prevention has become an even stronger National Patient Safety Goal identified by the Joint Commission (28) to help ensure that accredited facilities are making deliberate, focused efforts at suicide prevention, such as by incorporating screens for suicide risk.

Several examples of potential suicide screening and assessment tools are available in clinical settings. One such tool that has received positive reviews is the Columbia Suicide Severity Rating Scale (C-SSRS) (29), now promoted through the Columbia Lighthouse Project (30). It has the benefit of a toolkit that helps educate individuals using the materials about the screening questions, in plain English, regarding suicidal thoughts and is accompanied by further materials to help guide practitioners through more detailed assessments.

Another important screening tool is the nine-item Patient Health Questionnaire (PHQ-9), developed as a health care quality measure to address outcomes pertaining to depression. Several studies that have recently emerged in disparate populations (31) have shown the PHQ-9 to be effective also in examining individuals thought to be at risk of

suicide. As this research has evolved, there have been other studies showing that a shortened version, the PHQ-2, has not been as effective in screening for suicide risk because the particular two questions do not specifically ask about suicide, although they have some use in screening for depression (32).

Clinicians should be aware of the emerging literature on screening tools as a first step in approaching patient suicide risk in behavioral health care and general health care settings. Such screening tools identify individuals and protocols for next steps in more detailed assessments. Psychiatric assessments of suicide include a current mental status exam; an examination regarding the patient's history; any recent psychosocial factors; and a thorough understanding of what clinical issues might be present generally, as well as a specific suicide assessment related to ideation, intent, planning, activation toward executing a plan, and the like. A review of risk and protective factors is needed, with identified risk analysis and recommendations. To assist clinicians in following steps toward improved practices in suicide assessment and management, the Substance Abuse and Mental Health Services Administration has also developed a guiding protocol, called the SAFE-T (Suicide Assessment and Five-Step Evaluation and Triage) guide, which can be used with screening tools (33). It identifies the five steps as identifying risk factors, identifying protective factors, conducting the suicide inquiry, determining risk level/intervention, and documentation (33).

Documentation of the assessment conducted and of the reasoning and rationale behind the clinical recommendations, as well as notes about any safety planning when appropriate, can all be instrumental in reducing the risk of liability. Of course, not every word or act in a clinical encounter can be recorded in the medical chart, but the basics of the assessment, the risk analysis, the recommendations, and the follow-up plan will help in patient care going forward. It will also convey important information about what was done to identify risk, assess it, and ultimately mitigate the potential for suicide. Documentation will be used by the defense and by the plaintiff's experts in a malpractice case and will be more favorable to the defense if the evidence demonstrates reasonable care by a practitioner.

RISK MITIGATION STRATEGIES

Once screening and assessment of suicide risk have taken place, the psychiatrist should consider risk mitigation strategies to reduce the likelihood that the patient will commit suicide. When suicide is associated with active symptoms of mental illness, it is important to ensure that these symptoms receive proper attention. This might mean ongoing care in an outpatient setting or an increased level of care that would be medically appropriate (15). Specifically, a determination regarding hospitalization, partial hospitalization, and crisis services will be in order.

All states have means to involuntarily detain and then hospitalize individuals who are unwilling to seek treatment in the event of active suicidal intention through the civil commitment processes. Hospitalization is, of course, not a guarantee that a patient will not commit suicide. Efforts to reduce the risk of inpatient suicide have been recently updated (34, 35). These include attending to environmental issues, monitoring, and means reduction.

In addition to identifying the level of care and placement decisions needed for patients, it will also be important to treat symptoms with the proper pharmacological strategy and psychotherapeutic approaches. Patients with depression or psychosis will require a careful review of symptoms and effective treatments. Some medications have been shown to generally reduce the risk of suicide attempts, such as clozapine and lithium, and have been identified as medications that could be helpful in overall suicide prevention (36) when used for patients warranting those medications. Also, psychiatrists should familiarize themselves with the black box warnings related to elevated suicide risk noted for antidepressant medications, especially for children and adolescents (37). Although a review of this complex topic is beyond the scope of this article, one study suggested that prescribers might benefit from updates on these warnings to sustain impacts on practice (38); it is, however, still important to recognize major depression among youths and to provide effective treatment—including medications when indicated—with appropriate monitoring. With regard to therapies, cognitive–behavioral therapy and dialectical behavioral therapy are examples of modalities that have been shown as effective in reducing the risk of suicide for specific patients (39).

Counseling and guidance on substance use, whether the patient engages in binge use or has a pattern of more chronic use, must be considered as part of suicide risk mitigation in treatment. For example, alcohol misuse is associated with suicides (40), and opioid misuse is increasingly associated with suicides (41). Therefore, consideration of substance use counseling and even medications available as treatments for particular substance use disorders (e.g., alcohol and opioid use disorders) (41) can be part of an overarching suicide risk reduction strategy. In addition, involving reliable peer supports so patients with suicidal thoughts are not alone using substances may be important in individual cases. Overall, working with patients to recognize the risk of suicide when using substances is critical.

Additional safety planning and approaches are growing. For example, the Assess, Intervene, and Monitor for Suicide Prevention (AIM-SP) has shown promise for patients in clinical settings (42). Safety planning and intervention overall, after proper screening and assessment, are important strategies to reduce the risk of suicide. Some patients will present with new-onset, acute suicidal ideation, and others may have more chronic suicidal ideation. Also, as noted earlier, a portion of suicides will be impulsive and/or associated with substance use, and therefore may not be

foreseeable. Nonetheless, where suicide risk has been identified properly, risk mitigation strategies can involve collateral supports such as family or friends. Patients may not give authorization for communication with these individuals, so that if the risk is great and these supports are not able to connect with the patient, the clinician may need to consider a higher level of care. If supports are available, properly educating them about suicide and risk reduction and helping to determine safety planning are crucial. Also, helping patients and family members understand the risks of the patient being alone during high-risk periods, such as periods of high stress, is another approach to risk reduction that can be part of the overall safety plan. Involvement of family early on can also be very helpful in the event that there is an eventual suicide, because the lack of awareness that a loved one was seen in treatment and determined to be at risk can foment negative views that might create an increased risk of liability for the clinician. That said, as noted earlier, privacy issues need to be sorted out appropriately to involve any third parties. This includes the determination of whether there is an emergency justification to the communication even over the patient's objection or whether there are ways to work through any communication constraints to foster safety planning.

One review identified approaches for when suicidal ideation is more chronic and described that family and mental health treatment providers should include in safety planning attention to known warning signs and ongoing re-review of safety plans (43). Many of these principles can be true for patients with acute new-onset suicidal ideation as well, although reliance on an active therapeutic alliance will be less available (e.g., after new outpatient visits or after an emergency department visit), which is why the AIM-SP model is useful in providing structure for follow-up in general.

Basic safety planning also typically includes what to do if suicidal ideation or intent re-emerges and how to access emergency services. Means restriction counseling is another component of suicide risk mitigation (44), as noted earlier with firearms. Other means restriction approaches on a patient level, such as removing sharp objects, removing extra pills from medicine cabinets, and lowering the amount of pills prescribed at any given time, should be developed on a case-by-case basis. Although this article addresses individual liability issues in patient care, it is important to be aware of suicide prevention efforts at population levels (e.g., placing delays on purchasing firearms or putting fencing up on parking structures). Where there can be a delay in accessing lethal suicide means, the potential for suicidal acts can be reduced.

CONCLUSIONS

Suicide is a major cause of liability for mental health practitioners. In a legal case of malpractice, the plaintiffs will seek damages and will work to prove that there was a dereliction on the part of the physician in the patient–doctor relationship that directly led to the patient's suicide. Issues of foreseeability will be examined. To reduce the risk of liability, a prudent practitioner would do well to become familiar with basic approaches to suicide screening, proper risk assessment, and pursuit of appropriate treatments and safety planning for the suicidal patient. Monitoring and follow-up care will be examined in light of the assessment that was conducted—or should have been conducted—to mitigate the risk of suicide. As suicides are increasingly prevalent in society, more attention is being given to population-based prevention strategies. For the mental health practitioner, there is a critical opportunity to intervene on a patient level. Liability can be minimized if suicide risks are identified and appropriately addressed. This article attempts to highlight for practitioners the critical opportunity available to them to intervene and thereby reduce not only the risk of liability but also the risk of a tragic outcome for the patient, the patient's family, and the practitioner.

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