A HIGH RISK SITUATION: THE SUICIDAL CLIENT

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Background:

In the year 2002, 31,655 people in the United States died by suicide – that is 11 out of every 100,000 Americans. In 2004, 529 Minnesotans died by suicide. This rate is three times that of homicide. This rate has risen every year since 2000. Each day in the United States 86 people die as the result of suicide.

In Minnesota more than 3,900 were hospitalized with self-inflicted injuries. 52% of suicide deaths in Minnesota were due to firearms. 90% of suicides occur in association with mental health problems (including substance abuse and alcoholism). 50% who die by suicide are struggling with major depression, and the suicide rate of people with major depression is eight times that of the general population.

- **Three times as many women attempt suicide as men –**
- **But men are four times as likely to die by suicide than women**
- **Death by suicide has been more common among Caucasians than any other group, but in 2006 the rates for African Americans caught up, largely due to a climb in rates for young African American males**
- **Native Americans have a rate twice as high as any other group**
- **Suicide is the 2nd leading cause of death for persons between the ages of 15 – 34**
- **Elderly people who die of suicide are often divorced or widowed and suffering from physical illness; the highest rate is ages 75 - 84**

Evolving State of Knowledge:

Although much has been written about suicide during the past forty years and there has been considerable research world-wide, this does not mean that the field of suicidology or suicide prevention is a static field. The reality is that new perspectives and models continue to evolve. For example, the ***New England Journal of Medicine*** relatively recently published an article by David Bent & J. John Mann entitled "Familial Pathways to Suicidal Behavior – Understanding and Preventing Suicide among Adolescents." (v. 355, pp. 2719-2721 – Dec. 28, 2006) which is available to non-subscribers at **http://content.nejm.org/cgi/content/full/355/26/2729**

There are changes in patterns observed such as a major increase in suicide deaths among Hispanic women in Texas, attributed to the fact that a large number had begun making attempts using guns – a very lethal, and more typically "male" method. A recent update on the changing situation among African-Americans can be found in Normal L. Day-Vines (2007) article "The escalating incidence of suicide among African Americans: Implications for counselors" (**J. of Counseling & Development,** v. 85, pp. 370-77.)

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Practice Challenges:

Studies of stressors on clinicians usually rate suicidal clients as among the top three stressors on practicing clinicians. There are ethical issues, boundary issues, and legal risks in such cases. As with so many challenging issues of practice, these elements all interface and are not always easily separated. As with all ethical dilemmas, the initial challenge is to determine: **How urgent is the situation?** Decisions, for example, about breaching confidentiality in order to try to protect the client and prevent a suicide are based on the degree to which the matter is urgent.

You may be dealing with your own clients' potential for suicide, and that will vary with your role. The **Suicide Prevention Resource Center** website **(http://www.sprc.org)** permits printing out of customized guides to suicide designed for a variety of roles and professions. Some areas for consideration related to your own work or practice, your supervisory duties, or even provision of consultation to a therapist dealing with a suicidal client are as follows:

1) **Competence to Assess Risk:**

   (a) **There is a ethical duty to have periodic training or updating on this;**
   (b) **You should have available texts or manuals relative to judgment of suicide risk so that you can have a quick refresher**
   (c) **Assessing risk in children/adolescents vs. adults**

2) **Access to appropriate consultation in a timely fashion:**

   (a) **There is an ethical duty and practice challenge to have this in place before trouble happens;**
   (b) **You should always have a back-up consultant or two in case your primary consultant is not available.**

3) **Competence to provide appropriate management for the chronically suicidal client (the ethical duty is to have appropriate training and any tools available): Many professionals are not equipped to do this and need to be prepared to refer their client to someone with this specialty. Dialectic Behavior Therapy (DBT) is rapidly becoming the treatment of choice for those who are chronically suicidal.**

4) **Deciding when to breach confidentiality in order to prevent an imminent suicide (this has always been an option, but unlike the "duty to warn or protect" there are generally no standards in rule or law for when one takes this step). This can involve:**

   (a) **Contacting the client at home or work to follow-up on concerns**
   (b) **Contacting, without a release, other service providers to alert them to the risk or to obtain additional information**
   (c) **Contacting a family member or third party to alert them to the risk and ask for their assistance in intervention.**
   (d) **Having the police intervene and/or pursuing an emergency hold to involuntarily hospitalize the client.**

5) **Review of the situation in the event of an attempt or completion. If the client dies, a**

full review with an effort to understand why and how the suicide happened is worthwhile. It is sometimes called a *Psychological Autopsy.* This is helpful clinically in terms of sorting out what can be learned, but it is also helpful to the clinician trying to process what happened.

6) **Assistance to other clients, students, and affected parties. A suicide can have considerable impact on other clients, other staff, families, etc.** This may be done in an individual session, or a group meeting

7) **Self care for the practitioner after a suicide attempt or completion: this is mostly a supervisory duty – that is to insure that the practitioner has had any assistance needed to be able to deal with the impact on him or herself.** There is a website which is a project of the Clinician Survivor Task Force of the American Association of Suicidology which has a bibliography and annotated references, personal accounts, and clinician contacts. A web address which can access this unique resource is: **http://mypage.iusb.edu/~jmcintos/therapists_mainpg.htm**

8) **Reconsideration of practice parameters after a death of a client: the professional, and any supervisor, needs to consider whether any adjustment in practice is dictated by the impact of the suicide or suicide attempt.**

9) **Awareness of cultural differences:** There are huge international differences in suicide rates between various countries. The quality of the data varies, but generally speaking northern European countries have the highest rates (e.g. Finland, Norway, Sweden) and southern hemisphere countries (e.g. Ecuador) have very low rates. The same is true in the United States. Ethnic groups vary considerably as to suicide rates.

SOME GENERAL FACTORS PREDICTING RISK IN MAINSTREAM AMERICANS:

(1) **Statements that the person plans to kill themselves** (even if chronically made)
(2) **Existence of a plan: the more specific, more lethal, the higher the risk** (generally speaking, a vague plan is less dangerous than a specific one, and one that one has actually practiced such as putting a gun to ones head, or when one has checked to see if there are enough pills to do it, is more lethal)
(3) **Possession of the means to do it -- e.g. having a loaded gun with bullets**
(4) **Past attempts -- approx 80% of those who kill themselves have attempted it before**
(5) **Clinical depression --** approx. 15% of those with serious clinical depression kill themselves; the suicide rate for those with clinical depression is about twenty times that for the general population
(6) **Feelings of *hopelessness* are the most significant depressive thoughts associated with suicide and this is the best predictor variable**
(7) **Alcohol & drugs --** 1/3 to 1/4 of suicides are associated with alcohol as a contributing factor; alcohol and drug abuse in general are risk factors
(8) **Loss of a parent or other important person in one's life increases the risk, both acutely and on a longer term basis**
(9) **Serious health problems and pain can increase the risk, especially when chronic**
(10) **Loss of a job and unemployment increase the risk**
(11) **Risk is higher for those coming out of a depression or recently released from hospital care for depression**

Common Errors in the Handling of Suicidal Clients:

The most common errors relate to a failure to obtain a good history, failure to follow-up on intuition or "soft signs" and statements with more inquiry, or a failure to deal with your own cynicism, anger, or frustration with a long-term & chronically suicidal client. Writing the threat off as "just manipulation" is always dangerous.

Another common error is over-reliance on a client promise to not suicide. While useful in some clinical settings, there is no clear evidence that they actually work. There is nothing wrong with asking for such a contract, but the clinical and forensic opinion on this is that they are no better than the quality of the relationship with the client. There is a case in Illinois where a counselor and agency were faulted by a regulator for not having a "no suicide" contract with a client who made a serious attempt. However, the use of such contracts is not necessary to meet the standard of care.

A special problem is the handling of members of groups, especially refugees or immigrants, who come from cultures where mental illness is considered a sign of a family defect, sin, or some immoral conduct. Suicide is a serious sin in the Roman Catholic faith and in Islam, so people often will not discuss it. Raising this issue must be done with extreme caution when dealing with persons from Southeast Asia, Africa, and the Middle East.

An immigrant or refugee may have moved to a small town to avoid the shame of seeing compatriots who would realize the degree to which they had dropped in status. This may also, of course, take them away from traditional support and helpers, such as with Moslems a mosque or the services of a Sheik. Islamic "therapy" involves meeting with one or more Sheiks to read verses from the Qu'ran (Koran) and to pray.

In all cultures a personally humiliating event can be a precipitant for a suicide. There are cultural differences in what is likely to be the most humiliating event. For a Moslem immigrant from Africa, a young girl having an illegitimate child is most at risk. Mental illness may be humiliating. A man who falls in love and cannot afford a dowry is at risk.

When dealing with someone from another culture in which suicide is sinful, one has to assume that one is not necessarily going to get a clear answer to questions about suicidal thinking or intent. Furthermore, with a Somali, for example, feelings of hopelessness are not as serious as feelings of worthlessness. Religion is a protective factor, but cannot always be utilized by the health care practitioner. In the case of Hmong or other southeast Asians the family or clan may be essential if intervention is to be effective.

A number of professionals who testify in wrongful death cases now consider it essential to question clients carefully about the presence of guns in the home. They note that some gun-owners will not consider a gun as a "weapon" so that it is important to specifically inquire about **guns of any type.** Well-known forensic psychiatrist Thomas Gutheil indicated in a workshop in 2006 that even if the suicide was not via firearm, if the clinician had not screened for the presence of guns in the home, he generally will not take the defense side in a wrongful death case. **Screening for the presence of guns as part of a clinical intake or risk assessment is now considered the standard of care by a number of experts.**

The Evolution in the Handling of Suicidal Clients:

Recently there has been a major shift in the standards for handling of suicidal clients. There is an excellent resource on this topic in the form of a recent overview entitled 'Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice (Jobes, 2006; Jobes, Overholser, Rudd, & Joiner, 2008;).

A major shift has been occurring away from suicide risk factors to a focus on suicide warning signs which are specific to a given case. (cf. (Rudd, Berman et. al., 2006). These include:

- **Rage & reckless behavior**
- **Feelings of hopelessness**
- **Feeling trapped**
- **Anxiety and/or agitation**
- **Dramatic mood changes**
- **Emotional and Social withdrawal**
- **Lack of a sense of purpose in life – "no reason to live"**

For chronically suicidal clients, the focus on Dialectic Behavior Therapy (DBT), based on empirical data supporting its efficacy, is sharpening. Risk management is focusing away from reliance on hospitalization and medications alone.

Jobes et. al. (2008, p 406) present some case examples which illustrate the challenges:

- A chronically suicidal 19 year old had been in outpatient psychotherapy for 3 years. At a party he put a gun to his head and said "bye-bye" but friends wrestled it away from him. The next morning he denied any suicidal thoughts and signed a safety agreement. Two days later he was found hanging in a garage. The parents filed a malpractice suit, alleging that given his history of lying to adults, the safety agreement was inadequate as a response to the risk.

- A therapist contacted the insurance carrier for his 20 year old suicidal client. The therapist believed there was an imminent risk, but the company said that ideation alone was not sufficient to justify authorization for hospitalization. The therapist noted that the client owned a gun and threatened to use it, but because he hadn't asked whether the client had bullets, the company would not pre-certify the hospitalization. Days later the client shot himself and was on life support.
- A father contacted an outpatient therapist about his son who had frequent suicidal thoughts and overdoses. He had seen four different psychiatrists and not responded to a broad range of medications. He had been hospitalized six times and recently had been given ECT. However, he seemed to be doing worse. He had never had psychotherapy and the father thought that was worth trying.

The College Campus

There has always been a challenge concerning the suicidal student on a college or university campus. Such persons are typically of the age of majority and thus have full rights to their privacy, and yet they are often still supported by their parents and seen as sons and daughters who are not yet independent.

The challenge is whether to contact parents in the event of a significant emotional problem and/or suicidal thinking or potential. Parents often expect this even though according to both law and codes of ethics since the student is an adult legally the threshold is quite high for a situation to require the breaching of confidentiality.

This situation has become controversial enough to rate a front page story in the **Wall Street Journal.** Published in the Saturday/Sunday Weekend Edition for March 24-25, 2007 (Vol. CCXLIX, No. 69, pages A 1, A 6 & 7), the story was entitled "After a Suicide, Privacy on Trial" by Elizabeth Bernstein. It examined the outcome of a jury trial in a wrongful death case brought in 2003 by the parents of Chuck Mahoney who took his own life in a fraternity house at Allegheny College in Meadville, Pennsylvania.

Among the claims in the case were that Allegheny College officials should have, among other things, breached their son's confidentiality to get them involved in the situation. Since 1974 the FIRPA (Family Educational Rights and Privacy Act), which protects the privacy of educational records, has allowed school officials to contact parents in the event of an emergency situation (health or safety related). Furthermore, the release used at the college made it clear that in the event of an immediate threat to the client or someone else that confidentiality can be broken.

The College did have a waiver that students can sign to allow communication with parents, but Chuck had not signed it nor had his parents pushed him to sign. Present in the case were the usual dynamics of the privacy of a young man vs. the desire of parents to be helpful. In this case there were a number of consultations among school officials and mental health professionals and the professionals were concerned that breaking the confidentiality could lead to a very negative response.

The jury voted 11-1 for the defendants. According to the story:

> **In interviews, many jurors said that as an adult, Mr. Mahoney was responsible for his own actions. They believed his parents should have recognized how sick their son was after he was hospitalized, and that they had a responsibility to make sure he signed the waiver form that would have freed the school to more easily share information. "If I am flipping the bill for college, you are signing the waiver," says Tom Yoder, 43, a tool-and-die maker. The lone dissenting juror, Barbara Collins Zurovchak, felt the suicide warnings required action. "I believe that safety must trump privacy," the retired high school teacher says.** (Bernstein, 2007, p. A 7)

In 2002 MIT settled with the parents of Elizabeth Shin who set herself on fire in a dorm room in 2000. On the other side are cases in which colleges try to pressure students to take leaves of absence when they become troubled. Currently the dispute over this practice rages, with several successful suits against universities under the Americans With Disabilities Act (ADA). Some schools are requiring that troubled students get counseling and pressuring them to do so. Many who do kill themselves are not in any sort of counseling or therapy.

In 2007 the terrible mass killings at Virginia Tech University led to considerable national discussion and to an investigation as to how college officials handled the situation. In general the conclusions were that while campus police should have alerted the campus community to the situation earlier, it is possible that nothing would have prevented the killings.

Although there have been newspaper editorials trying to second-guess the situation and noting that various privacy laws and rules prevented some communication from service providers to the college, there is no convincing evidence that such communication would have made a difference. The reality is that a very troubled young man – who had been referred for and received help of various types – ran amok and killed a number of people.

The Virginia Tech events are a stark reminder of the challenges which colleges and universities have in dealing with young adults who are having breakdowns. Furthermore, issues of access to care and some challenges in providing community mental health services seem as critical as does the balancing of privacy rights with safety.

WEBSITES & INTERNET:

The internet has a huge body of resources for learning more about suicide and suicide prevention, including:

- **Suicide Prevention Resource Center:** http://www.sprc.org – Among the many resources on this site are a set of customized manuals for various types of people from teens to clinical social workers. You can download and print out a primer for a number of types of professionals.

- **American Association of Suicidology**: http://www.suicidology.org

- **American Foundation for Suicide Prevention:** http://www.afsp.org

- **National Center for Injury Prevention and Control:** http://www.cdc.gov/ncipc/ -- part of the Centers for Disease Control and Prevention

- **National Suicide Prevention Lifeline**: http://www.suicidepreventionlifeline.org/ Toll – free phone for information to providers at (800) 273-TALK (8255)

- **Suicide Prevention Action Network USA**: http://www.spanusa.org Dedicated to leveraging grassroots support among suicide survivors (including family members)

BOOKS, MANUALS, & ARTICLES:

- American Academy of Child & Adolescent Psychiatry (2001). Practice parameter for the assessment and treatment of children and adolescent with suicidal behavior. **J. of the Amer. Acad. of Child & Adol. Psychiatry**, 40 (7 Suppl), 24S – 51S (members of the Academy can obtain the full text from the Academy website: http://www.aacap.org

- American Psychiatric Assn. (2003). **Practice Guidelines for the Assessment and Treatment of Patients With Suicidal Behaviors.** Arlington, VA: American Psychiatric Assn. http://www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf
- Berman, A., Jobes, D., & Silverman, M. (2006). **Adolescent Suicide Assessment and**

Intervention, 2nd Edition. Washington, D.C.: American Psychological Assn.

- Bongar, B. (2002). **The Suicidal Patient: Clinical and Legal Standards of Care.** New York: Guilford Publications

- Goldston, D. (2002). **Assessment of Suicide Behaviors and Risk Among Children and Adolescents.** Bethesda, MD: National Institute for Mental Health(NIMH) **http://www.nimh.nih.gov/suicideresearch/measures.pdf**

- Jobes, D.A., Overholser, J.C., Rudd, M.D., & Joiner, T.E. (2008). Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice. **Professional Psychology: Research and Practice.** V. 39, pp 405-413.

- Jobes, D.A. (2006). **Managing suicidal risk: A collaborative approach.** New York: Guilford Press.

- Joines, T.E. Jr., Van Orden, K.A., Witte, T. K, & Rudd, M.D. (2009). **The Interpersonal Theory of Suicide: Guidance for Working With Suicidal Clients.** Washington, DC: American Psychological Association.

- Rudd, M.D., Berman, A.L., Joiner, T.E., Nock, M.K., Silverman, M.M., Mandrusiak, M. et. al. (2006). Warning signs for suicide: Theory, research and clinical implications. **Suicide and Life-Threatening Behavior,** v. 36, pp. 255-262.

- Rudd, M.D., Joiner, T.E., & Rajab, M. (2004). **Treating Suicidal Behavior.** New York: Guilford Press.

- Wenzel, A., Beren, G.K., Beck, A.T. (2009). **Cognitive Therapy for Suicidal Patients – Scientific and Clinical Applications.** Washington, DC: American Psychological Assn.

VIDEOS & TRAINING FILMS:

The Suicidal Patient: Assessment and Care. Developed by the American Foundation for Suicide Prevention & Kingsley Communications in 1999, this is available from the American Foundation for Suicide Prevention at **http://www.afsp.org/survivor/doctor.htm**

There is a growing concern, reflected in professional literature & public media, about suicides in young people who are on anti-depressant medications. While not fully understood, in some the risk of attempts may increase while on anti-depressants. The exact risk-related parameters are not clear, although some theorize that this is caused by excessive stimulation from SSRI's when the dosage is too high. They warn that signs of agitation such as shaking hands should be seen as a danger signal. Suicide deaths do not increase – just thoughts or attempts. This is an evolving issue.

Monetary Damages Not Available for Managed Care Organization's Negligent Failure to Authorize Psychiatric Hospitalization and Resulting Suicide Attempt; Ruling Not Disturbed [from **Developments in Mental Health Law,** 2007, vol. 26, #5 -- edited]

A series of widely publicized instances of fraud and mismanagement of employee pension funds

in the early '70s led to Congressional passage of The Employee Retirement Income Security Act of 1974 (ERISA). ERISA also applies to employee health insurance plans… Today, such plans are the primary means by which most Americans obtain health care.

ERISA was designed to protect and regulate employee benefits in part by preempting (i.e., replacing) the wide range of state laws that governed these benefits at the time and replacing these laws with a universal, albeit relatively limited, set of remedies should abuse or mismanagement of these benefits occur.

As managed care came to play a predominant role in determining whether health care services are available, a series of lawsuits was filed against managed care organizations (MCOs) charging that they had wrongfully denied requests for these services and that these denials harmed the petients. Many of these lawsuits charged that these wrongful denials constituted medical malpractice because necessary medical care was not forthcoming as a result, and thus the MCO should be subject to a tort action for damages under a given state's medical malpractice laws.

Ultimately the United States Supreme Court ruled that ERISA preempts state malpractice actions against MCOs and limited injured parties to the remedies established by ERISA. *Aetna Health Inc. v. Davila, 542 U.S. 200 (2004)*. They could not receive "make-whole" relief that would compensate them fully for the damages incurred as a consequence of the denial of coverage.

It has been argued that ERISA has evolved into a shield insulating MCOs from liability "for even the most egregious acts of dereliction." *DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 453* (Becker, J., concurring). A concurring opinion filed in Davila joined "'the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime.'" *Davila, 542 U.S. at 222* (Ginsburg, J., concurring)

It has been suggested that monetary relief might be available from the administrators of a health benefit plan if it can be shown that they violated their fiduciary obligations under the plan (e.g., by establishing that they failed to solely focus on promoting the interests of the participants in the plan as required of a fiduciary when they instead made profitability their primary goal).

The Second Circuit rejected such an interpretation. In this case, a plan beneficiary brought a lawsuit against his health insurance company, Empire Blue Cross and Blue Shield ("Empire"), and the company that performs utilization review of mental health services for Empire. He alleged that the defendants had negligently failed to authorize his hospitalization in a psychiatric facility and as a result of this negligence he suffered permanent injury from a failed suicide attempt

The Second Circuit concluded, however, that the monetary damages the plaintiff sought were precluded under ERISA and that monetary damages were no more available from a plan fiduciary than from a non-fiduciary. Review was sought from the United States Supreme Court in an effort to reverse the Court's precedent on this matter or, alternatively, to invite recognition that monetary relief under ERISA is more widely available in suits against ERISA fiduciaries than against non-fiduciaries. The United States Supreme Court, however, declined to review the Second Circuit's ruling. Rubin-Schneiderman v. Merit Behavioral Care Corp., 193 Fed. Appx. 70 (2d Cir. 2006), cert. denied, 127 S. Ct. 967 (2007). The Second Circuit decision can be found at **http://www.ca2.uscourts.gov** .