A HIGH-RISK SITUATION: THE SUICIDAL CLIENT

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Introduction

- Current levels are the highest in 30 years. Overall rates were up 37% from 2000 to 2018 –the highest since 1986. During this same period Minnesota's rates were up 48%.
- One of the largest increases was for children aged 10 to 14. African American children in that age group had a 60% increase for boys, and 182% increase for girls.
- A **Nov. 4, 2019 article by Carol Giacomo in the *NY Times*, *Suicide deadlier than combat for the military*,** reported that for veterans aged 18 to 34 the rate went up nearly 80% in a decade. It noted that 45,000 active duty and vets had killed themselves in the past six years.
- An **Oct. 28, 2019 article in the *Boston Globe*,** was titled ***Former Boston College Student charged with involuntary manslaughter in suicide of boyfriend.*** The grand jury finding related to alleged continual harassment of a young man by his girlfriend driving him to suicide. There have been other similar cases reported elsewhere involving documentation provided by emails and text messages.
- Prior to such criminal cases there are a number of well-documented instances of harassment of young people on social media which may have played a key role in a suicide.

A caution about numbers -- reporting of suicide varies so that comparisons between areas cannot be exact. It is widely believed that suicide is under-reported and that a percentage of "accidental deaths" may be suicides. Religion and culture may also impact on reporting if there is shame associated with suicide or it is a serious sin. Families or officials may hide suicides.

In 2017 Minnesota's suicide rate was 13.8 per 100,000 people, slightly lower than the 14/1000 US rate. North Dakota was 12.58, but South Dakota was 18.2 (with Buffalo County having a whopping 63.62) Wisconsin's was 14.36 and Iowa 14.41. Other states ranged from New Jersey's 8.4 to Montana's 23.74/100,000. This rate has risen yearly since 2000 and is nearly five times the rate for homicide. More than 40,000 Americans kill themselves every year. Counties within states vary considerably – there is not an even distribution across states.

- **Twice as many women *attempt* suicide as men**
- **But men are 3.7 times as likely *to die* by suicide than women**
- **Death by suicide is highest common among Native Americans, with Caucasians the next highest – African Americans, Hispanics, Asians are lower**
- **Suicide is the 2nd leading cause of death for persons between the ages of 10 – 34,**
- **Elderly people who die of suicide are often divorced or widowed and suffering from physical illness**
- **Each suicide death was estimated to affect the life of six others – thus nearly 4,000 Minnesotan residents were affected by a loved one's suicide**

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There is an ever-expanding literature regarding various sociometric factors such as which groups are affected more than others. (Olfson et. al., 2017) 90% of suicides occur in association with mental health problems (including substance abuse & alcoholism). 50% who die by suicide have major depression, and the suicide rate of people with major depression is eight times that of the general population. Go to **www.sprc.org** for more information.

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. The Suicide Prevention Resource Center email list is a good way to keep informed about the evolving knowledge base. It is at **www.sprc.org**

As noted earlier, the issue of **high rates of suicide among American soldiers has become a major concern during the past 5 years.** There is an extensive public discussion and professional literature, and this is a topic unto itself. Studies have examined predictors, family history, combat conditions, and a variety of other factors.

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 review of 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.)

A study based on comparing data from the Youth Risk Behavior Survey (YRBS) for 1991 to 2011 found that there was a large decrease in the report of suicidal thoughts by both male and female students. However, during that same time period there was no change in prevalence of suicide among male students and only a slight decrease among females. This raises the possibility that impulsive attempts are more common and the authors pointed to the possibility of more screening questions related to some risk correlates such as injection drug use which was a factor for both males and females. (Lowry et. al., 2014)

There have also been suggestions that there be screening of students, and also in different studies that there be routine screening of medical patients. There is no good evidence that broad screening aids in prevention of suicide at present. Even though a large percentage of suicides involve persons who have sought health care in the preceding year, it is not clear that there is any meaningful screening which would be able to prevent attempts.

Impact of the Pandemic

During the first six months of the pandemic a number of risk factors increased significantly, but thus far suicide rates have not shown much change. However, the situation could change the longer this situation exists. (Moutier, October 2020)

Among the risk factors one of the most serious is the fact that U.S. firearms sales increased by 85% in March 2020 compared with March of previous years. (http://smallarmsanalytics.com/v1/pr/2020-04-01.) Minnesota saw such an increase at that time.

Social isolation is another potent factor which increased dramatically. Access to support services, groups, and health care in general also became a significant problem. An apparent increase in drug and alcohol use also represents an increase in risk. Alcohol sales have increased (Chaudury, Aug. 4, 2020) as have overdose deaths (Alter & Yeager, June 2020). Substances are present in 1/3 of toxicology reports from autopsies of suicide victims (Ertl et. al., 2019).

It has been argued that a number of national efforts are possible which could make a significant difference and that at present there is an opportunity to address this as a major public health challenge and opportunity. Moutier (October 2020) makes a number of thoughtful proposals.

Practice Challenges

Studies have shown that having a suicidal client is one of the top three stressors on practicing clinicians. Suicide has many impacts on practitioners (cf. Gulfi et. al., 2010). There are ethical issues, boundary issues, and legal risks in such cases. The Black Lives Matter crusade and concern about police violence has greatly complicated decision-making as regarding calling police for intervention.

As with all ethical dilemmas, the initial challenge is to determine: **How urgent is the situation?**

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: Many professionals are not equipped to do this & need to be prepared to refer their client to someone with this specialty. Dialectic Behavior Therapy (DBT) and similar approaches are the treatment of choice for those who are *chronically* suicidal.**

4) **Deciding when to breach confidentiality in order to prevent a 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) **<u>Review of the situation in the event of an attempt or completion.</u> 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) **<u>Assistance to other clients, students, and affected parties</u>. 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) **<u>Self care for the practitioner after a suicide attempt or completion</u>: 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) **<u>Reconsideration of practice parameters after a death of a client</u>: 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) **<u>Awareness of cultural differences</u>:** There are large differences in suicide rates between various countries. Northern European countries have the highest rates (e.g. Finland, Norway, & Sweden). 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** (a vague plan is less dangerous than a specific one, & one that has actually practiced such as putting a gun to the head, or checking to see if there are enough pills to do it, are 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 --** 15% of those with serious clinical depression kill themselves; the suicide rate for those with clinical depression is about 20X 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 of suicides are associated with alcohol and/or drugs 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**

Breaching Confidentiality to Prevent Suicide

Generally speaking, it is presumed that when there is an imminent threat, breaking confidentiality to alert a relative, friend, the police, or some other party to prevent a suicide is justified. A number of "duty to warn" standards also include breaching confidentiality to prevent a suicide. The one exception is substance abuse programs in which CFR-42 does not permit such breaches. Most would argue that there is an ethical duty here, whether or not the law authorizes it. In Minnesota licensed LADC's and programs are required to warn clients that they might break confidentiality in such an instance, and the presence of a duty is found in the licensure law.

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. **Currently the top experts recommend against "no suicide contracts," partly because they are not really negotiated with clients but represent therapist demands. Top experts prefer a crisis card which involves client-generated actions when the client is feeling suicidal. This also involves constructing a "hope box" – a suicide prevention tool box.** (e.g. Jobes, 2006)

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 or sin. Suicide is a serious sin in the Roman Catholic faith and in Islam, impeding discussion. Raising this issue must be done with extreme caution when dealing with persons from 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.

ACCESS TO GUNS

A number of professionals who testify in wrongful death cases 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.** (e.g. McCourt & Vernick, 2018)

Evolution in Approaches to Working With 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 an overview entitled 'Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice" (Jobes, Overholser, Rudd, & Joiner, 2008). I would also highly recommend **Managing Suicidal Risk: A Collaborative Approach** (Jobes, 2006) which has a good deal of useful information including some useful scales.

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. There is other evidence that other treatment regimens also lower the risk.

Risk management is focusing away from reliance on hospitalization and medications alone. **Although sometimes a hospitalization is utilized due to the seriousness of the threat, hospitalization alone does not bring down the suicide rate and some people make attempts in the hospital or upon discharge become high risk all over again.**

Yaseen and colleagues at Beth Israel Hospital in New York have reported on their research on the development of a **Suicide Trigger Scale (STS-2).** This work was presented at the May 2011 convention of the American Psychiatric Assn. Thus far inpatients have been studied and the factors identified with predictive power have been (a) "near psychotic somatization" and (b) "ruminative flooding and frantic hopelessness." Although a workable scale has not yet been developed, the researchers feel that they have identified a unique clinical entity related to suicidal triggering.

In an article published on line on 10 February 2014, ***Focusing Suicide Prevention on Periods of High Risk,*** which can be accessed on-line, Olfson, Marcus, & Bridge argue that suicide prevention needs to be focused on high-risk periods. They note that **the period immediately following hospital discharge** is one such period, and note that most of those discharged do not have follow-up outpatient care for weeks. Yet that period of time accounts for 24% of all suicides. They cite a study from the United Kingdom in which a 7-day follow-up reduced rates from 24.8 to 19.5/100,000 during the 3 month period following discharge. The second period is that which **follows an emergency room visit for self-harm.** About one half were discharged without a mental health assessment or special care plan. Yet the data shows that 15% of those who kill themselves have at least one emergency room visit for self-harm in the preceding year.

Jobes et. al. (2008, p 406) present some case examples which illustrate the challenges and also the change in response:

- 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 tragedy is a stark reminder of challenges which colleges and universities face in dealing with students who are having breakdowns. The issues of access to care & challenges in providing community mental health services seem as critical as does the balancing of privacy rights with safety. The Colorado theater massacre in 2012 had a connection to a college campus in that the killing was done by a student who was forced to drop out of graduate school due to mental health problems. The killer was receiving psychiatric care on campus prior to the killings.

A growing number of cases involving multiple shootings end with suicide, or with a person setting up a situation where law enforcement kills them. Certainly, there is an element of desperation in these acts and the suicidal element is undeniable. One particularly pernicious type of suicide is the person who confronts law enforcement with a weapon and basically has someone else perform the act.

WEBSITES & INTERNET

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

- **Suicide SAFE-T:** www.samhsa.gov SAFE-T Suicide Assessment Five-step Evaluation & Triage. You can download this two page guide to assessment.

- **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. Has an excellent publication, **After a Suicide: A Toolkit for Schools** (2018) developed with the American Foundation for Suicide Prevention.

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

- **Mass Prevents Suicide:** www.massprevents.suicide.org Has a downloadable brochure, "Saving Our lives – Transgender Suicide: Myths, reality & help.

- **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)

- Pamela Wible, MD, has a site and listserve focused on suicide in doctors and dealing with distress in doctors: Pamela@idealmedicalcare.org

BOOKS, MANUALS, & ARTICLES

- 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

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- **SAMHSA** (2008) **Substance Abuse & Suicide Prevention: Evidence & Implications – A White Paper** www.samhsa.gov.shin

- Wenzel, A., Brown, 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 the wide range of state laws that governed these benefits at the time and replacing these laws with a universal 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 patients. 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 this interpretation. In this case, a man 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 that the monetary damages the plaintiff sought were precluded under ERISA and that monetary damages were not available from a plan 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** .

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