Minnesota – March 2024

A HIGH-RISK SITUATION: THE SUICIDAL CLIENT

Gary R. Schoener*

Introduction

- Current levels are the highest in 30 years. A report by Eve Bender on Dec. 28, 2023 in **Medscape Medical News**, noted that the sharp rise in US suicide rates from 1999 to 2020, with firearms and hanging the major methods. Largest increases were in Caucasian men and American Indian/Alaskan natives.
- 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.
- Deaths from suicide increased 60% from 1999 to 2018.
- **Nov. 4, 2019 article by Carol Giacomo in the *NY Times*, *Suicide deadlier than combat for the military,*** reported that veterans aged 18 to 34 the rate went up nearly 80% in a decade. s.
- 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 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 2023 Minnesota's suicide rate was 13.1 per 100,000 people, lower than the 14.3/100,000 US rate. North Dakota was 18.2, but South Dakota was 21. Wisconsin's was 14.5 and Iowa 18. Other states ranged from New Jersey's 7.1 to Wyoming's 30.5/100,000. This rate has risen yearly since 2000 and is nearly five times the rate for homicide. More than 50,000 Americans killed themselves in 2023 – the highest in history. Counties within states vary considerably – there is not an even distribution across states. Rural areas are typically higher than urban areas.

- **In Minn. 65% of attempts ending in hospital care were by women.**
- **But in Minn. men accounted for 80% of suicide deaths.**
- **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 who suicide are often divorced/widowed & 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 last year.**

Gary Schoener, M.Eq., LP, Director, Institute for Consultation & Training, Walk-In Counseling Center, 2421 Chicago Ave. S., Mpls., MN 55404. grschoener@walkin.com

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. One study found rates of suicide were more than 40% higher in women living with gun owners (Miller et. al., 2022). Self-harm varies with things such as sex offender history, and whether treatment is inpatient. (Stinson, Gonsalves, 2014). Go to **www.sprc.org** for more information on incidence and prevalence.

Despite increasing suicide rates and deaths (60% increase from 1999 to 2018) and national attempts to provide help, there has been no significant increase in the access of mental health care by those who are suicidal in the USA (Bommersbach et. al. 2022). The COVID pandemic also impacted on the numbers for various groups within the population.

Emergency Resources

Resources vary county by county in Minnesota and in most parts of the USA. Populous counties with larger mental health needs like Hennepin County have a greater range of resources for both suicidal persons and those who are concerned about them (family, friends, counselors). It is important for service providers to know in advance of resources for consultation and/or intervention, as well as those that a client or family member might access.

Hennepin County has child and adult crisis resources which can intervene in a variety of ways including going out to a person's home. **COPE now has a line to access services at (612) 596-1223. 911 is the all-purpose "call for help" line useful in many circumstances. Canopy Mental Health provides a crisis service similar to COPE but it applies only to situations in the City of Minneapolis. It is accessed through 911.**

988 is now the number for the National Suicide Prevention Hotline, simplifying access. There is also text access -- 741741
There are also other hotlines and "warm lines" which can be helpful.
Do your homework in terms of best local resources for a given client.

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 10 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. Lethality of various methods ranges from firearms (83% – 91%), drowning (66% - 84%), down to cutting/piercing (1%-3%),

and Poison/drug (2%) (Miller, Barber, Azrael, 2016).

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." This literature is continually evolving in the counseling and psychotherapy fields.

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 COVID – 19 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) Overall suicide deaths declined by 3% although they rose in some groups – most notably in young people.

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.[1] Minnesota saw such an increase during that time period.

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

[1] http://smallarmsanalytics.com/v1/pr/2020-04-01. Small Arms Analytics has a section on news about small arms sales and related matters.

concern about police violence has greatly complicated decision-making as regarding calling police for "wellness checks" or intervention with mental health crises in some communities.

As with all ethical dilemmas, the initial challenge is to determine: **How urgent is the situation? Dealing with an immediate threat is a very different proposition from trying to help someone who has chronic suicidal thoughts. Having a specific plan with the means to carry it out remains the most serious single predictor along with any history of attempts – especially serious ones. Feelings of hopelessness are also a predictor of acute risk.**

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 an 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 clear standards are lacking. 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.
    (e) Contacting the county sheriff regarding suicide risk (ERPO)

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, and 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 ensure 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. **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 recently released from hospital care for depression**

Treatment Protocols

Some organizations and facilities have specific treatment protocols for cases in which there are high risk factors related to potential suicide. Professionals who work for such facilities need to be mindful of any such protocols and decide if they fit a given case. In some programs there are specific rules or expectations that when there is suicide risk a staff member is required, or expected to, seek supervision.

In recent years there have been treatment planning guides which provide potential guidance in high-risk situations.[2] There is no definitive guide that is broadly accepted in any of the psychotherapy or counseling fields, and the practitioner needs to assess the various evidentiary bases cited in a manual or treatment planner.

Murder/Suicide

Unfortunately, there are situations where someone murders someone as part of a suicide. This can occur accidentally, of course, in a situation where someone is reckless and brings about the death of someone (e.g., car crash) but it can also be a murder. In some situations where there is a family break-up, one party may kill other family members and then kill him/herself. In the April 2023 mass killing in a Louisville, Kentucky bank, there was evidence that the shooter had communicated suicidal thought shortly before he went to the bank and did the killing.

The Minnesota Supreme Court gave an opinion in ***Smits v. Park Nicollet Health Services*** on September 7, 2022, which addressed such a situation. The case involved Brian Short, a nurse and business owner who was struggling with some stressors and went for help, receiving treatment (medications & some counseling) over a three-month period for anxiety and depression. He deteriorated and eventually killed himself, his wife, and his three children with a shotgun. The case involved a summary judgement motion in an action brought by the estates of the wife and children.

In ***Smits*** the Supreme court agreed with the appellate court that there was no duty to the family members who were killed on the part of the care providers. There had been no threat or warning so this was not a "duty-to-warn" nor was there a duty to protect. However, the Supreme Court also affirmed the appellate court's opinion that the defendants did owe a duty of care to Mr. Short and that part of the case could move forward. The plaintiff's experts questioned the medication management and decision-making as well as several other elements of the care provided. They also noted that the high level of agitation made Mr. Short a higher risk, even though he denied any suicide plan or that he was high risk.

The case has a number of interesting facts. Mr. Short did have a shotgun, but it was in storage. He purchased another shotgun with which he committed the murder/suicide. No suicide rating scale was used, but he was repeatedly given a PHQ-9 which showed him to be quite depressed.

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

[2] A good example is Klott, J. & Longsma, Jr., A.E. (2015). **The Suicide and Homicide Risk Assessment & Prevention Treatment Planner.** Hoboken, NJ: John Wiley & Sons

is justified. A number of "duty to warn" standards also include breaching confidentiality to prevent a suicide. This can range from calling law enforcement for a "wellness check" or involving a crisis service which is able to visit a family home in a crisis. Beginning in 2024 in Minnesota there is a duty to contact the county sheriff when you believe there is a risk of suicide due to the ownership of a gun.

The one exception to breaching confidentiality in connection with suicide risk is in substance abuse programs in which federal law, CFR-42, does not authorize 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 substance abuse treatment 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.[3]

Unlike the "duty to warn" of client violence towards third parties, there are no clear standards or directions as to how and when to breach confidentiality.[4] Beyond contacting law enforcement, for example, what about contacting relatives or roommates?

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 commit suicide or self-harm. **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[5], 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

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[3] This is a long-standing problem in that the Federal law does not authorize such a rationale for breaching confidentiality, but the state licensing law authorizes it. The obvious solution would be for the federal rules to be changed. This was done as regard child abuse reporting in 1987.

[4] Starting this year, 2024, in Minnesota, there is specific guidance on one point. If a mental health professional believes that a client who owns a gun is at risk of self-harm, the professional has a duty to contact the county sheriff in the county in which the client lives to alert the sheriff to this risk. The professional is also expected to make recommendations concerning the client's possession of the weapon. At first glance this law would appear to relate only to clients at risk. If a family member approaches the professional about someone who is not a client, the duty would be to advise the family member about options. The duty to contact the sheriff seems to apply only to situations where the person at risk is a client.

[5] Suicide is mentioned in the Qu'ran (Koran) and carries a penalty of eternal damnation, including repetition of the suicidal act through all eternity.

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 a most seriously humiliating event (i.e. a devastating event). For a Moslem immigrant from Africa, a young girl having an illegitimate child may be at extreme risk. Mental illness may be humiliating and thus a diagnosis can be tragic for some. A man who falls in love and cannot afford a dowry is at risk in some situations.

When dealing with someone from another culture in which suicide is considered 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 potentially 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. Cultural awareness and sensitivity are essential when dealing with thoughts of self-harm or suicide attempts.

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)

Extreme Risk Protection Order (ERPO)

In 2023 the Minnesota Legislature passed a bill which was a part of a large public safety omnibus budget bill. A section relating to mental health professionals states:

> **"When a mental health professional has a statutory duty to warn another of a client's serious threat of physically violent behavior <u>or determines that a client presents a significant threat of suicide by possessing a firearm</u>, the mental health professional must communicate the threat or risk to the sheriff of the county where the client resides and make a recommendation to the sheriff regarding the client's fitness to possess firearms."** [Minn. Session Law, Ch 52, Art. 14, section 2, subdiv. 5]

This is a new law and various professions are discussing its implications. It imposes a duty to breach privacy and also a duty to evaluate "fitness to possess firearms."[6] It would apply to any mental health profession which has a "duty to warn" included in their licensure law.

<u>I would strongly advise practitioners to follow the discussion of this law and/or get involved in</u>

[6] The law does not offer a definition for the term "possess firearms." Does this mean that the client owns a firearm? What about situations where the client has access to a firearm but does not own it? What about situations in which the client owns a firearm but it is allegedly in the possession of someone else. What if it is in storage somewhere?

the reviews being done by Minnesota's professional organizations. It is going to be important for all to understand the implications of this law as well as to seek education and training concerning the duties it imposes.

This law contains protection from civil suit or licensure action for either taking action, or deciding to not take action in such cases. However, there are no guideposts or legal standards for determining that a client "presents **a significant threat of suicide by possessing a firearm."** This is likely a lower threshold than the current understanding of breaching confidentiality to try to prevent a suicide where the threat is imminent. There also remains a key question as to what notice of this duty should be in a client information or consent statement.[7]

ERPO is a procedure through which family members or law enforcement can challenge a person at risk's right to have a firearm. A hearing is then heard and the court can order seizing of the weapon (Conrick et. al, 2023, provide an excellent overview of these so-called "Red Flag" laws which are currently in 20 states and the District of Columbia.

Gun Violence & Suicide

There is an excellent and comprehensive resource on gun violence which I would highly recommend for a good review of the relevant literature: **Gun Violence and Mental Illness.** Edited by Liza Gold and Robert Simon, it was published by the American Psychiatric Assn. in 2016 but is still considered an excellent overview. It provides a great range of data relevant to gun violence and mental health considerations.

Evolution in Approaches to Working With Suicidal Clients

There has been a major shift in the standards for handling of suicidal clients. An excellent resource on this topic is 'Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice" (Jobes, Overholser, Rudd, & Joiner, 2008). I recommend **Managing Suicidal Risk: A Collaborative Approach** (Jobes, 2006) which has a good deal of useful information including some useful scales. Another good resource for counselors is **Suicide Assessment and Treatment Planning** (Sommers-Flanagan, J. & R., 2021) just published by the American Counseling Assn.

For chronically suicidal clients, the focus on Dialectic Behavior Therapy (DBT), based on empirical data supporting its efficacy, is a treatment of choice, and a large number of programs/clinics now offer DBT groups and/or programs. There is other evidence that other treatment regimens can also lower the risk for chronically suicidal clients. Where chronic suicidality is a key aspect of the situation a referral for DBT is advisable.

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.**

[7] ERPO is a duty tied to concerns about a client. It does not specify duties concerning others about whom a client might have concerns. If someone is providing services to a spouse who is concerned about their partner, it is unclear what duties exist with regard to danger posed by someone who is not a client. It is important to note that the source of information on which a report is based is not specified as being the client. So if the spouse, child, or friend of the client is the source of the information action might be required.

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

- **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"**

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) presents some case examples which illustrate the changes in response:

- A chronically suicidal 19-year-old was 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. 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 agreement was inadequate 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.

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 balancing of privacy rights with safety if a challenge. 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. This has been termed "suicide by cop."

Recently a key issue has emerged relating to discontinuity of services to students when they are put on leave due to a mental health crisis and suicidality. The **Washington Post** (27 March 2023) included an article by William Wan entitled "Yale's changes mental health policies for students in crisis – The university had been under fire for pressuring suicidal students to withdraw." This issue had received considerable visibility after the suicide of a student, Rachael Shaw-Rosenbaum who feared she would be kicked out if she had another crisis. A related issue was also raised about the fact that Yale's insurance coverage was unavailable to students when they most needed help.

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. SPRC 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 listserv focused on suicide in doctors and dealing with distress in doctors: **Pamela@idealmedicalcare.org**

BOOKS, MANUALS, & ARTICLES

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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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