

Objectives

- Identify issues defining the Standard of Care and Malpractice litigation
- Discuss ethical issues and dilemmas
- Review best practices in school suicide preventions

Clinical Suicidology

- The risk of suicide is a remarkably common clinical presentation that generates a great deal of fear and anxiety among mental health professionals who typically receive little, if any, formalized training in suicide risk assessment and treatment (Bongar, 1991).
- In the United States clinicians primarily learn about working with suicidal patients by having suicidal patients or from supervisors who, themselves, had little to no formal training. Formal (systematic, skill-building, competency-focused) training in suicide assessment and treatment is rare.

Malpractice

- Survey data suggest that one in two psychiatrists and one in five psychologists will lose a patient to suicide over the course of a 20 year career (Chemtob et al., 1988, 1989).
- No other patient behavior generates more stress and fear among mental health professionals than the potential of a suicide (Pope & Tabachnick, 1993).
- In recent years there have been exponential increases in suicide-related malpractice liability law suits against mental health clinicians (Jobes & Berman, 1993).
- Malpractice lawsuits are one of the top ten growing areas of contemporary litigation (Weich, 2000).
- Over 50% of family members who survive a loved one's suicide consider contacting an attorney; 25% actually engage a lawyer (Peterson, Liotta, & Dunne, 2000).
- One in six suits against psychiatrists (2000-2009) involves claims of malpractice as the primary cause of suicide/attempted suicide by their patients (Simon, 2011).

Risk Management

1. Know general principles of clinical risk management
 - Understand ethics and legal statutes
 - Learn about malpractice cases
 - Understand rules of confidentiality
 - Apply patient's informed consent
 - Use good business practices
 - Consult
 - Know good documentation and record keeping (HIPAA)
 - Carry malpractice insurance
2. Know issues pertaining specifically to suicide and malpractice liability
 - Legal awareness
 - Policies and procedures statement
 - Clinical competence
 - Documentation

Suicide Bereavement

- Volitional death = rejection
- Often sudden and unanticipated
- Often traumatic and violent
 - witnessed or discovered
- Stigmatic
- Implied guilt, hostility
- Compromised mourning rituals
 - Distorted communications
 - Changes in social supports (survivors as lepers)

Socio-cultural History

- Early religious sanctions
 - St. Augustine (4th c): *Thou shalt not kill* (neither another or oneself). Suicide equated with homicide – violates God's ownership of human life.
 - To prevent premature entry into heaven
- Roman sanctions
 - Criminals, soldiers [a soldier who tried to kill himself would be charged with "desertion"], slaves -- a slave can not steal himself away from his master ["good help was hard to find"]
- Britain: *Felo de se*
 - 14th c. English common-law: Suicide = crime
 - Forfeiture of estate, mutilation of corpse, non-consecrated burial ground, fear of ghosts

Past



400BC Hippocrates attributes suicide to melancholic humor



1600's Spinoza suggests suicide is caused by physical or psychological 'duress'



1628 Robert Burton publishes *The Anatomy of Melancholy*



1827 Esquirel suggests that the majority of people who die by suicide are mentally diseased

(Adapted from Cutter 1998)

Modern History

- Suicide is not of sound mind, not responsible
- Who to blame?: God – A & N; Man: H & S
- Prevention: Society and its agents as custodial caretaker
- Compassionate concern for survivors

Custodial Caretakers

- Employers
- Product Manufacturers
- Therapists
- Institutions [hospitals, penal, religious...]
- Schools
- Hotels
- Family Members

Tort Law

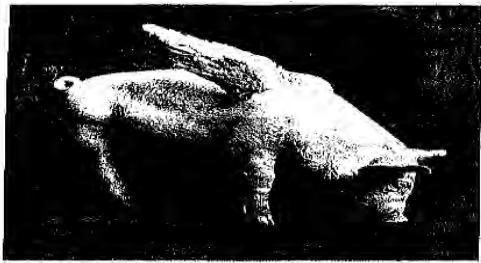
- Tort: a civil wrong
- Tort Action: a request to the court for compensatory damages where it can be shown that a custodial caretaker committed a tort that caused injury to another.

Negligence

- An act of Commission or Omission
- 4 D's
 - Dereliction of
 - Duty
 - Directly causing
 - Damages

Standard of Care

- The "average" practitioner
- "Reasonable and prudent"
- Of similar training
- In same or similar locality
- Opined by "experts"



In a courtroom, anything will fly if a scientist testifies to it.

The Typical Complaint: Failure to:

- Protect patient from known danger to self
- Assess adequately risk for suicide
- Secure past medical records and inform self of past treatment history
- Develop treatment plan in accordance with risk for suicide...
- *Possess adequate degree of skill and training to adequately assess and treat suicidal patient*

Deposition Discomfort Questions

- How many years have you been in practice?
- On average, how many patients do you see per week?
- What proportion are likely to be suicidal?
- Guesstimate total # of at-risk patients.
- Recall formal didactic training in graduate/medical school?
- Attended any CE workshops on assessment and treatment?
- Books read?, research articles...?

Malpractice Actions: Disposition

- The Good News:
 - Summary Judgment: approx 20-40%
 - Settlement: approx 50-75%
 - Trial: approx 5-10%
- The Bad News
 - The process can take years
 - The outcome is uncertain
 - You still have to work
 - You could lose...

Standard of Care Interventions

- Assess and formulate level of risk
- Protect vs. self-harm
 - Restrict Means
- Monitor/observe: decrease isolation
- Formulate active treatment plan
 - Functionally analyze motive/intent
 - Decrease perturbation
 - Decrease risk: increase protection
- Implement active treatment plan
- Be available and accessible

Common Management Errors

- Unmanaged counter-transference hate (malice, aversion...)
- Excessive reliance on clinical intuition
- False beliefs (contracts, scales, “gestures”)
- Burnout
- Disturbed professional relationships
- Prevention by impersonal means
 - Maltzberger (1989)

Outpatient Suicide: Common Failure Scenarios

- Failure to properly evaluate need for psychopharmacological intervention or unsuitable pharmacotherapy
- Failure to specify and implement criteria for hospitalization
- Failure to maintain appropriate boundaries
- Failure to evaluate suicide risk
 - At intake
 - At management transitions

Outpatient Suicide: Common Failure Scenarios

- Failure to secure treatment history/records or conduct adequate history
- Failure to conduct MSE
- Failure to diagnose
- Failure to establish formal treatment plan
- Failure to safeguard outpatient environment
 - Failure to adequately document clinical observations, judgments, and rationales
 - Bongar, Berman, Litman, & Maris (1992)

JCAOH Sentinel Events: Suicides

[N = 857 since 1995 (#4)]

1995-2000 Contributors

- Patient assessment - 95%
- Physical environment - 73%
- Orientation and training - 64%
- Communication - 42%
- Information availability - 32%
- Staff competence - 18%

2004-2010 Contributors

- Patient assessment - 80%
- Communication – 62%
- Physical environment – 51%
- Human factors – 48%
- Leadership – 46%
- Information management – 24%

Source: The Joint Commission

Inpatient Suicide: Common Failure Scenarios

- Failure to properly evaluate need for psychopharmacological intervention or unsuitable pharmacotherapy
- *Failure to follow P & P's*
- *Failure to implement hospital safeguards*
 - Failure to supervise; failure to remove sharps, unsafe premises, etc.
- Failure to treat or treat appropriately
- *Improper discharge*

Risk Factors for Suicide (OR's): The Question of Risk Resolution?

Qin & Nordentoft, 2005; Cheng et al, 2000, Shaffer et al, 2000

- **Discharge from psychiatric hospitalization**
 - Last week 278 x
 - Last month 133 x
 - Last year 34-61 x
- Prior attempt (adol) 22.5 x
- Substance abuse (adol) 7 x
- Firearm in home 5 x

RE: Discharge

- Those at greatest risk following discharge:
 - Affective disorders (with symptom improvement)
 - Brief hospital stays
 - Limited external resources

RE: Failure to adequately document clinical observations, judgments, and rationales: When to Document

- At first psychiatric assessment or admission.
- With occurrence of any suicidal behavior or ideation.
- Whenever there is any noteworthy clinical change.
- For inpatients:
 - Before increasing privileges/giving passes
 - Before discharge
- The issue of firearms:
 - If present - document instructions
 - If absent - document as pertinent negative

WHAT TO DOCUMENT IN A SUICIDE ASSESSMENT

- Document:
 - The risk level
 - The rationale for the risk level
 - The treatment plan for reducing the risk

Example: This 16 y.o. high school student is experiencing his first episode of major depressive disorder. In spite of his denial of current suicidal ideation, he is at moderate to high risk for suicide, because of his depression, his continued anxiety and feelings of hopelessness. He does not want to be, and is unlikely to be, hospitalized. The plan is to see him 3x a week, with alternate daily telephone check-ins, have consultation (with his OK) with his parents, and immediately refer for a Rx consultation. Reassess in 1 week.

Broad Documentation Recommendations

Documentation Strategies

- When documenting a suicide risk assessment, include both current and historical (acute and chronic) risk factors, observations from the session, rationale for actions taken, or considered but not taken, and follow-up plans, including a response plan when there is evidence of increased suicide risk.
- Document pertinent negatives, as much as possible.

Documentation Recommendations

- The patient's actual statements (quotes if possible) regarding the increase or alleviation of suicidal thoughts
- The content of discussions about risk and safety
- Any contemporaneous information provided by concerned family members
- Any attempts to obtain prior treatment records
- All increases in treatment intensity or frequency
- Any special precautions taken, or arrangements made
- Any attempts to have the patient voluntarily admit himself or herself to a hospital
- All reasons why hospitalization was rejected as an alternative
- Evening, weekend, and emergency arrangements that were made

(Baerger, 2001)

General Guidelines for Practice and Treatment

- *Provide sufficient informed consent about confidentiality and safety as earlier as possible in the clinical relationship.*
- Always be sure to ask about suicide directly, forthrightly, with no judgment or threat.
- Thoroughly assess suicide risk and try to gather and evaluate multiple sources of risk data (e.g., behavioral observations, verbal interviewing, use of assessment instruments). *Do not rely solely on the presence or absence of suicide ideation.*
- Formulate an overall assessment of suicide risk and document the risk in the client's record (e.g., a judgment of Low, Medium, or High Risk based on what evidence).
- Establish a clear treatment plan with the client as to how suicidal thoughts, feelings, and behaviors will be managed on an outpatient basis.

Guidelines Continued

- Closely monitor and document on-going suicidality until it resolves.
- Consider and use all appropriate modalities (e.g., various forms of psychotherapy, vocational counseling, medication, etc.).
- Collaboratively assess and modify with the client the treatment plan as needed.
- Routinely seek professional consultation and document any consultation.
- Document the resolution of suicide risk; monitor for any future reoccurrence
 - *Do NOT rely on the absence of suicide ideation as a criterion for low suicide risk...*

Do patients who die by suicide admit to suicidal thinking?

- The majority of patients who die by suicide actually *deny* having suicidal thoughts when last asked prior to their death or communicate their risk in more behavioral versus verbal messaging.

Appleby et al., 1999; Barraclough et al., 1974; Busch et al., 2003; Chavan et al., 2008; DeLong & Robins, 1961; Hall et al., 1999; Hjemeland, 1996; Isometsä et al., 1995; McKelvey et al., 1998

IS PATH WARM?

- **I** Ideation/threatened or communicated
- **S** Substance Abuse/excessive or increased
- **P** Purposeless/no reasons for living
- **A** Anxiety, Agitation/Insomnia
- **T** Trapped/feeling no way out
- **H** Hopelessness
- **W** Withdrawal from friends, family, society
- **A** Anger (uncontrolled)/rage/seeking revenge
- **R** Recklessness/risky acts - unthinking
- **M** Mood changes (dramatic)

WHEN A SUICIDE OCCURS

Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice

Approximately, 12,000-14,000 suicides per year occur while in treatment.

To facilitate the aftercare process:

- Ensure that the patient's records are complete
- Be available to assist grieving family members
- Remember the medical record is still official and confidentiality still exists
- Seek support from colleagues / supervisors
- Consult risk managers

Special Issues and Professional Challenges

1. Issues of counter-transference
2. Issues of abandonment
3. Informed consent
4. Decision to hospitalize
5. Confidentiality
6. Commitment to Treatment
7. No Suicide Contracts vs. Safety Contracts

Issues of Counter-transference

Malice and Aversion (Maltzberger & Buie, 1974)





Treatment of the Suicidal Patient: Manage Counter-transference

(Berman, Jobes, & Silverman, 2006)

- Self-monitor affect, personal issues
- Limit at-risk patient load
- Seek greater competency
- Overhaul treatment of refer if not effective
- Seek support and consultation
- Tolerate affect, reactivity: “Maypole”; “sponge”
- Keep clear expectations
- Remember transference rules
- Play good parent role
- Change attributions:
 - resistance, manipulation

Unilateral Termination and **Clinical Abandonment**

- From an ethical standpoint, one cannot “abandon” an on-going patient.
- Abandonment is “pulling the plug” in the middle of care, unexpectedly, with no follow-up, referral, or bridging to other care.
- It is not unethical to carefully orchestrate an end to care for thoughtful reasons—that are well documented—over time with further referrals offered...

Informed Consent, Agreements and the Question of Risks?

- Mental Health professions in stark contrast to medical professionals in statement of risks of care/treatment
 - Medical procedures routinely incorporate risk estimates (e.g. oncology, surgery, medications)
- Expectations of risk for death and injury differ for mental health professionals?
 - Why?
 - Clear data to suggest risk of suicide and suicide attempt for those with identified disorders and pursuing treatment
 - Clearly relates to the standard of care and public expectations

What is an Accurate Statement of the Risk of Treatment?

- Should we say something like this (to patient or parent):

If you've experienced suicidal thoughts and/or engaged in suicidal behavior in the past (or are currently experiencing one or both of these problems), the possibility of a suicide attempt during outpatient care exists. The rates of suicide and suicide attempts during outpatient treatment are difficult to estimate, but are relatively low for those with no or one previous suicide attempt, and noticeably higher for those with 2 or more previous suicide attempts. In particular, for individuals that have chronic problems involving suicidal behavior (e.g. repeated suicide attempts), one of the risks of outpatient psychotherapy is death (by suicide), although this is infrequent and relatively rare in outpatient care. We will talk more specifically about the issue of suicidal thoughts and behavior in our commitment to treatment agreement. In particular, we'll come to an agreement about how to address the emergence of suicidality in treatment, particularly the use of a crisis response plan...

Involuntary Hospitalization: Typical Substantive and Miscellaneous Criteria for Civil Commitment/Assisted Treatment

- Substantive Criteria
 - Mentally ill
 - Dangerous to self or others
 - Unable to provide for basic needs
- Miscellaneous Criteria (in conjunction with one or more of the above criteria)
 - Refusing hospitalization
 - Lacks capacity to make rational treatment decisions
 - Hospitalization represents least restrictive alternative
 - Danger to property
 - Unable to care for self to point of likely self-harm

Hospitalization Does Not Prevent Suicide

- **PSYCHIATRIC INPATIENTS: SAMPLE ATTRIBUTES (n = 76)**
 - > 50% had no history of a prior attempt
 - 42% on 15-minute checks
 - 9% on one-to-one checks

● Busch KA et al. *J Clin Psychiatry* 64:14-19, 2003.

Confidentiality

- While fundamental to establishing an alliance, in cases where the patient or the community needs to be protected from imminent danger, confidentiality may be breached, i.e. confidential information about the patient may be disclosed to a third party.
 - American Psychiatric Association Practice Guidelines (2003)
- Parents of minors have right to know; however, this must be therapeutically selective.
- Police, emergency personnel, significant others...

What's a Commitment to Treatment Statement?

- *An explicit agreement that identifies patient and clinician responsibilities in ongoing care. Such an agreement always includes a crisis response plan and incorporates behaviors consistent with the patient's identified level of competence and unique to his or her presentation.*

Making Reasonable Agreements

- *Commitment to treatment statement*
 - Individualized
 - Concrete and specific
 - Enhanced individual responsibility
 - Commitment to living
 - Does not imply giving up control or *right to suicide*
- *Crisis response plan*

Elements of a Good Agreement?

- Defined as a commitment to
 - Living
 - Treatment and care
- Incorporates a crisis management or response plan
- Specifically identifies responsibilities
 - Patient
 - Clinician

Why? -- Non-adherence

● Youth at risk are notoriously reluctant to seek (and to receive offered) help

■ Wilson et al (*Journal of Youth and Adolescence*, 2010): *The higher the level of SI and general psychological distress, the greater the avoidance of seeking help*

● High rates of non-adherence

• Very few youth who died by suicide were found to have been positive for *prescribed* antidepressants
– Dudley et al (*Australasian Psychiatry*, 2010) – 9/574 (1.6%) youth suicides (6 studies) had recent exposure to SSRIs.

Commitment to Treatment Statement

- Includes behaviors for which the patient has demonstrated competence
- Is modified routinely
 - At request of patient or clinician
 - When indicated by clinical markers

Commitment to Treatment Statement

- *I agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment including:*
 - *attending sessions (or letting you know when I can't make it)*
 - *voicing my opinions, thoughts, and feeling honestly and openly, whether negative or positive*

CTS (continued)

- *being actively involved **during** sessions*
- *completing homework assignments*
- *experimenting with new behaviors and new ways of doing things*
- *taking medication as prescribed*
- *implementing my crisis response plan.*

CTS (continued)

- *I also understand that, to a large degree, my progress depends on the amount of **energy** and **effort** I make. If it's not working, I'll discuss it with my therapist. In short, I agree to make a **commitment to living for ... [a defined period of time, to be revised, then]***
- *I also understand that we are working toward the common goals of:*
 - *Reducing my symptoms and upset*
 - *Improving my quality of life*

No Suicide Contracts: Positives

- OK as an assessment tool – notice ambivalence, nonverbal cues, hesitancy to contract as evidence (leakage) of intent when a patient has, otherwise, denied intent.
- Tests adequacy of therapeutic alliance
- Identifies super-ordinate treatment goal
- Supports patient’s coping skills

When Contracts are *NOT* Appropriate

- High (imminent) risk patients
 - Acute and chronic distinctions
- Severely compromised competence
 - Symptom type and severity
- Lack of commitment
 - Objective and subjective evidence
- Inability or unwillingness to engage in collaborative care

Some Troubling Trends and Questions?

- Evidence of lack of formal training and theoretical models for use with suicidal patients
- Evidence of increasing use with those at higher risk: **80%** of inpatient units
 - Despite a lack of data on effectiveness
- Evidence of high-rates of attempts/suicides while in use
 - 41% made an attempt, completed suicide

Crisis Response/Safety Planning: An Orientation and Philosophy of Care

- The central treatment goal is to establish a viable outpatient treatment plan that can keep the patient *out* of the hospital.
- This goal is largely achieved by the careful development of a Crisis Response Plan (or Safety Plan).
 - Be clear about the legal statutes pertaining to imminent danger to self; overtly discuss goal of developing a viable outpatient treatment plan
 - Provide direction and guidance about the goal of establishing stability and outpatient safety
 - Emphasize mutual give and take
 - Be transparent, let the patient know your thinking and your agenda
 - Empathically appreciate suicidality as a means of dealing with seemingly unbearable pain
 - However, always raise the question: Is suicide in fact the *best* way to cope?

Crisis Response Plan (Continued)

- Negotiate around time considerations and explore possibilities for delaying suicidal behavior in lieu of trying new and better ways of coping (self-soothing).
- The value of *delay, distract, and redirect...*
- Continuously seek a good faith, time-specific, willingness to give treatment a chance.
- Clinical care should focus on:
 - (a) increasing pain tolerance
 - (b) creating alternative and better ways of coping
 - (c) ultimately making a life worth living

Crisis Response Planning: Key Treatment Conditions

1. Attend treatment reliably as scheduled over the next one to three months
2. Reduce/eliminate access to lethal means
3. Develop and use a Coping Card
4. Create interpersonal supports

Crisis plan: Coping Card

Try to distract myself
 Do things that have helped me feel better
 •Watch TV, draw, paint, surf internet, run in the park
 •Repeat any and all above
 Think: "I have tried this before – it will end soon"
 Write my thoughts down in my diary
 Take medication as prescribed
 Repeat. "I have promised not to hurt myself"
 Call my therapist: (tel #:)
 Call my parents (tel #:)
 Call Lene (tel #:)
 Call Jacob (tel #:)
 If the thoughts continue, get specific, and I find myself preparing to do something, Call Lifeline 1-800-237-8255 or
 Take a taxi to psychiatric emergency room at [Hospital with Address]

Crisis Response Plan Pointers

- Be specific
 - when to use, steps to take, where to go, what numbers to call
- Be concrete
- Ensure safety, remove access, availability
- Make it accessible
 - put on a card, can be carried in a wallet or purse
- Practice, role play
- Periodically review and update

Crisis Response Plan (CRP) Components

- Define *crisis*
- Identify trigger(s) and associated thoughts, feelings (suicidal belief system)
- Productive response to deactivate suicidal mode
- If not successful, access emergency care and assistance in manner that facilitates skill development

Part 2: Ethical and Legal Issues in the Treatment of Suicidal Youth

- ### Part 2a: Interactive Hypotheticals: A Fishbowl Exercise
- Non-adherent adolescent
 - Barriers to care
 - Non-adherent family
 - Lack of payment
 - No hospitalization agreement
 - Under the influence
 - Demand for confidentiality

- ### (A) The Case of Annie D (1)
- **October 20:** 13 y.o. female admitted to ED post-OD of 20-30, Extra Strength Tylenol tablets.
 - Precipitating event: Conflict with parents over clothing she wears and music she listens to.
 - *“Better to die than to deal with current problems”*
 - Hx of anxiety and oppositional-defiant behavior; Hx of anger control problems
 - Current sx of depression; grades declining this year and recent in-school detentions
 - Makes suicidal threats when angry when demands not met
 - Family hx for depression/anxiety (father, older sister)

Annie D (2)

- Transferred from the ED to inpatient psychiatry.
- Dxs of Adjustment disorder w/ depressed mood, and hx of social anxiety.
- Discharged after 3 days -- She was remorseful about her suicide attempt and denied further SI; referred to an outpatient psychiatrist whom she saw three days later, then in weekly, then bi-weekly sessions.
- He diagnosed her as having Adjustment disorder NOS; Oppositional-defiant disorder, and Borderline personality traits, noting ongoing problems with anger and impulsivity; and that she historically made suicidal threats when her demands were not met.

Annie D (3)

- *In her weekly sessions she consistently denied having SI.* He prescribed an SSRI and a mood stabilizer, but three weeks after prescribing it he learned that *her family had not filled the Rx for the mood stabilizer.*
- At times, Annie missed her appointment because of one or another problem her parent(s) had in getting her to treatment.
- As her treating therapist, what would you do?

Annie D (4)

- One night, 15 days after her last appointment, Annie became upset and angry at her parents over the choices offered for dinner, went to her room, sprayed herself with hairspray, and set herself on fire.

(B) Case of Mariah M. (1)

- Mariah M, age 19, is being seen 2x/week in outpatient psychotherapy. Her principal dxs are: BPD, dysthymic disorder, and bulimia nervosa. There is a suspicion of dissociative disorder as well.
- She is intense, unstable, anxious, often rageful and self-attacking. She has a morbid fear of being destroyed as punishment for these destructive outbursts.

Case of Mariah M. (2)

- Concurrently, she is very bright, wry humored, verbally adept, and challenging.
- She has an intense transference relationship with her therapist, often sexualized. She was terrified of abandonment, fearing that he would not return, that his plane would crash, from any vacation or business trip. She expresses suicide ideation in anticipation of losing him.

Case of Mariah M. (3)

- She is reliant on her family's insurance to pay for therapy, but their policy has an annual cap of only \$2,000 for mental health outpatient care.
- She has been in treatment, described as progressing well, for almost two years and has amassed an outstanding balance of \$17,000, expected to yet increase by about \$8,000 per year.
- As her treating therapist, what would you do?

C. Case of John M. (1)

- John, age 21, has been suffering from depression for almost 4 years. He has intermittent SI and has made two suicide attempts, one of which resulted in a 4 day hospitalization last year. He had a very negative experience in that inpatient stay and has vowed never to go back to the hospital.

Case of John M. (2)

- He is referred to you for outpatient treatment. At his first session, he asks what your policy is about hospitalizing patients and states that he will only work with you if you agree never to hospitalize him. Moreover, he asks that you agree to not, under any circumstance, communicate with his parents, who are paying for his treatment.
- As his treating therapist, what would you do?

(D) Case of Phillip R. (1)

- Phillip, 18, is a high school senior in outpatient therapy with you. He has diagnoses of Major Depression, and Substance Abuse Disorder (Accutane, Alcohol). He has a history of three SAs, all under the influence of alcohol.
- You have been seeing him for three months. At tonight's appointment, you smell alcohol on his breath and he is words are slurred. He plans to drive home.
- As his treating therapist, what would you do?

Part 2b. Suicide and Schools: Legal Issues and Best Practices



Reality

- Schools and school personnel, such as administrators, counselors, psychologists and teachers have been sued following the suicide of students.
- The most common basis for the lawsuits was *failure by school personnel to notify parents when they had reason to believe that the student was suicidal.*

Best Practices

- Suicide prevention, intervention and postvention recommendations have been made by all relevant school professional organizations (NASSP, NASP, NASN and ASCA, to name a few)
- There are both state and national prevention initiatives and schools need to link with community resources and agencies to work on prevention.

Best Practices

- Schools are encouraged to form a suicide prevention task force to review the incidence of suicidal behaviors in their school and to develop policies, procedures, and prevention programs. In many jurisdictions, school superintendants have mandated that schools develop suicide prevention programs.
- The Task Force will be the most effective when community mental health, law enforcement and clergy are represented in addition to school leaders.

Best Practices

- Awareness training on warning signs for all staff
 - See www.suicidology.org (*IS PATH WARM*)
- Suicide lethality assessment training for key staff
 - See School Suicide Prevention Accreditation Program (www.suicidology.org)
- Policies and guidelines for parent notification and supervision and support services for suicidal students
- Referral procedures for community services and monitoring and follow up at school

Best Practices

- Keep up with prevention literature and current trends (e.g. hanging deaths have increased for middle school age youth)
- Implement depression screening programs such as SOS* and TeenScreen,* which research studies have found to be effective and recommended by many professional associations

* see Evidence-Based Practices (www.sprc.org)

Legal Issues

- Liability after a suicide in a school is a very complex issue and the outcomes of court cases have varied considerably.
- Many cases are settled out of court and cannot be used as legal precedent.
- Courts have in most cases upheld immunity of schools; but schools are the most vulnerable when students talk or write openly about suicidal plans and schools fail to increase supervision, provide or secure counseling services, and/or notify parents.

Legal Terms

- “In loco parentis doctrine” raises the question of whether a special relationship exists between school officials and students, as students are released by parents for control and supervision by school officials.
- Negligence involves injury or damage to another person through breach of a duty owed. Foreseeability applies.

Landmark Cases

- Eisel vs. Board of Education Montgomery County 2nd Federal Court 1991 found that even when a student denies suicidal intent, a collaborative school team has an obligation to notify parents if the team suspects the student to be suicidal.

Landmark Cases

- Wyke vs. Polk County School Board 11th Federal Circuit Court 1997 found the district liable for not offering a suicide prevention program, providing inadequate supervision of a suicidal student, and failing to notify parents when their child was suicidal.
- The junior high student twice attempted suicide at the school.

Landmark Cases

- Szostek vs. Fowler and the Cypress-Fairbanks School District 189th District Court (1993) found the school had not negligently disciplined the student who died by suicide and was entitled to sovereign immunity. This case does highlight that school discipline has been a common precipitating event for suicide and raises questions as to how to discipline with sensitivity to the possibility of suicide.

Landmark Cases

- Brooks vs. Logan Idaho Supreme Court (1995) found the teacher and the district were immune from liability for failure to warn parents even though the student who died by suicide had written extensively about suicidal plans for his class assignment

Bullying and Suicide

- Latest term is “bullicide” as a number of parents have sued schools claiming that their child’s death by suicide was the result of the school’s failure to stop known bullying
- *Secord vs. the Anoka-Hennepin ISD* was one such case, as the parents blamed bullying at school for the suicide of their child. The court found in favor of the school system in summary judgment

High vs. Pasco School District

- A 6th grade student was assaulted and threatened with death by another student, two years older, on school grounds. The bully was known to be a threat to the safety of others. A school administrator suspended *both boys* for fighting. The bullied youth became depressed and ultimately died by suicide. Family sued the school for wrongfully punishing the victim of bullying.
- Case settled out of court.

Prevention and Mental Health

- In *Mares vs. Shawnee Mission Schools* Johnson County District Court (2007) the school system settled out of court after being sued following the suicides of two brothers. Key issues in the case were suicide prevention and postvention procedures and whether mental health services are the responsibility of schools?

Best Practices for Schools

- Keep up with the literature and develop policies and procedures for suicide prevention, intervention, and postvention.
- Review your state requirements and initiatives for suicide prevention.
- Train school personnel annually on the warning signs of suicide and the importance of working as a team member.

Best Practices

- Keep records that school staff were trained in suicide prevention and include aides and bus drivers in addition to teachers.
- Secure specialized training for personnel such as counselors, psychologists, nurses and social workers who will be assessing suicide lethality.
- Include suicide prevention, intervention, and postvention in school crisis plans.

Best Practices

- Keep records of specialized training and membership in professional associations.
- Develop policies for supervision of suicidal students and prompt and same day parent notification
- Be familiar with local emergency procedures, as some states have enacted legislation to address suicidal emergencies

Q: Preventing Suicide: Why should we even try?



A: Because no one should make a life or death decision when in despair and psychological pain. Because we can turn hopelessness into hope...

Contact

- berman@suicidology.org
- AAS website: www.suicidology.org



AMERICAN ASSOCIATION OF SUICIDOLOGY

AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts to suicide prevention through research, education and training, the development of standards and resources, and survivor support services.
