Probable Standards of Care for Suicide Risk Assessment

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Abstract

The legal standard of care for assessing and responding to suicide risk has historically been ambiguous. This likely creates inconsistency in the testimony of forensics experts and puts practitioners at greater risk of liability. Both circumstances leave our field vulnerable to intrusive legal decisions. To fill this gap, I propose six standards that I believe can be derived from legal and forensic scholarship. I review the basis for each standard and offer commentary to aid in their interpretation.
Patient suicide is a hazard of the worst kind: It cannot be controlled or predicted. Despite this grim reality, judges and juries must decide whether care rendered to suicidal patients was adequate in eyes of the law. For this, they rely on a combination of statute, historical legal decisions, and, importantly, testimony by forensic experts. A frequent question judges and juries must answer is (oversimplified): Was the patient’s suicide risk competently assessed and responded to? Because there are no agreed-upon standards for conducting suicide risk assessments, judges and juries must sort out the legal truth from the competing testimonies of experts on both sides. This is an equally frustrating situation for practicing clinicians who must care for suicidal patients under constant threat of liability but without the benefit of knowing what legally is the right thing to do.

To clarify matters, I propose a set of probable standards for suicide risk assessment, which I derived from negligence law, court cases, and forensic scholarship. I say “probable” to convey the hypothetical nature of the standards; legal standards of care are defined by courts not by practitioners.¹ Unfortunately, when courts do settle on a standard of care, they typically do so in a way that narrowly applies to the facts of one case. My intent, however, is to imagine standards that can be flexibly applied to any malpractice case involving suicide while avoiding excessively prescriptive actions (e.g., “clinicians shall”). A probable set of standards may benefit the field by improving current suicide assessment practices and by informing training curriculums for pre-licensure candidates. They also may help forensic experts comprehensively assess clinical care in malpractice cases and insulate their testimony from personal biases.
What Is Reasonable?

The doctrine of negligence law expects people to exercise “reasonable care” when their actions (or lack of action) pose a risk of injury to others. Failing to do so constitutes negligence. In most cases, jurors are entrusted with determining what constitutes reasonable care in a particular circumstance. However, they need guidance to understand what reasonable care means in situations requiring special knowledge—such as the treatment of a patient at risk of suicide. The law provides for this by giving jurors specific instructions. For example, in California, jurors are informed that the standard of care (SOC) to use is “…the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [practitioners] would use in the same or similar circumstances” (Ref. 2, p 382). Jurors are then instructed to rely on expert testimony to understand what “reasonably careful” practitioners do. Although some jurisdictions use the standard of medical custom, I focus exclusively on the reasonable person standard because the national trend is in this direction\(^3\) and courts have historically not deferred to medical custom when, in its view, the disregard for a precaution—no matter how routine—creates an unacceptable risk of harm.\(^4,5\)

According to legal scholars, the reasonably careful person possesses a number of qualities. The reasonably careful person is attentive, gathers information in order to fully appreciate the nature and degree of risk, anticipates the likelihood and severity of harm, weighs the pros and cons of different actions, takes precautions that reduce or eliminate risk, and monitors for changes in the risk picture.\(^6\) Naturally, these same qualities should be evidenced by practitioners completing a suicide risk assessment (SRA).
Because the reasonable person standard is a general one, courts ask forensic experts to establish standards of medical care, relevant to a case, against which to judge practitioners. For SRAs, forensic experts have expressed a continuum of opinions about what the standards are. The opinions range from “there can be no standard” to “there are many specific standards.” Representing the former are Simon and Shuman\(^7\) who persuasively argue that SOCs for suicide risk assessment are “elusive” because states define the SOC differently, the facts and circumstances of a case shape the SOCs, and experts commonly disagree on what constitutes the SOC.

There are several drawbacks to this view of standards for SRAs. First, the absence of standards can undermine objective analysis of malpractice cases by expert witnesses.\(^8\) Second, standards that are created solely by the particulars of one case leaves practitioners rudderless: None can know what to do but are nevertheless expected to do it (whatever “it” is). Finally, leaving the SOC undefined does not advance the national agenda to address the profound dearth of graduate training in suicide risk assessment.\(^9,10\)

For other experts, only detailed standards for SRAs and prescribed courses of action suffice.\(^11-13\) For example, Rudd and Joiner\(^13\) give a checklist of three domains and 23 areas they believe constitute the SOC for suicide risk assessment. However, the more exhaustive the SOC, the more likely it is to reflect ideal rather than reasonable care and so is more akin to clinical practice guidelines. Another concern is that a detailed checklist may lead jurors to believe that missing one or two areas is negligent. Last, overly detailed standards lack flexibility; they are too rigid to apply across settings (i.e., in emergency room versus inpatient settings) and do not easily allow for developments in the science of suicide risk assessment.
Staking out a middle ground are experts who recommend certain actions to minimize liability exposure. As such, the recommendations are typically prescriptive and are intended to avoid negligent treatment of at-risk patients. For example, Baerger\textsuperscript{14} offers five recommendations: (1) conduct an examination inclusive of current and historical suicidal thoughts and behavior; (2) when risk is high consider hospitalization or a safety plan; (3) reassess risk during stressful periods; (4) maintain records that justify treatment decisions; and (5) take special precautions for at-risk patients. Others experts offer lists of treatment failures when conducting SRAs.\textsuperscript{15}

**Probable Standards of Care for Suicide Risk Assessment**

To imagine probable SOCs, I relied on legal scholarship in tort law, court cases involving suicidal behavior, forensic papers on SRAs, and, to a lesser extent, clinical practice guidelines. From these, I distilled common components that could be the basis for probable SOCs. Next, I attempted to write the SOCs in way that is less about prescribing care in a specific circumstance (as clinical guidelines aim to do) and more about communicating expectations for reasonable care that can be flexibly applied to diverse clinical situations. Each standard is followed by commentary that elaborates on its basis and that supports its interpretation.

**Standard 1: Gathering Information from the Patient**

*To the extent that the patient is cooperative and the treatment context permits, the clinician inquir**ies about current suicidal thinking, surveys current and historical suicide risk factors, and assesses mental status.*

The law expects the reasonable clinician to competently diagnose and treat patients. Courts have concluded that making a diagnosis means “ascertaining a patient’s medical condition through examination and testing” (Ref. 16, at 7) and have frequently held that diagnosis includes
assessing suicide risk,\textsuperscript{17} which involves components such as assessing mental status,\textsuperscript{18} taking an adequate psychosocial and self-harm history,\textsuperscript{19} and thorough follow-up questioning regarding psychiatric symptoms.\textsuperscript{20} Thus, omitting an SRA as part of the diagnostic progress is akin to failing to appreciate risk\textsuperscript{6} and is evidence of inattentive care.

Courts also have accepted that suicide risk is established by evidence of a variety of risk factors\textsuperscript{21} and that demographic factors alone are likely inadequate.\textsuperscript{22} Thus, Standard 1 requires clinicians to fully appreciate suicide risk by inquiring about the major areas of inquiry: current suicidal thinking, current and historical risk factors, and mental status. Clinicians should also personally complete an SRA, an expectation shared by the courts.\textsuperscript{23,24}

Many forensic experts believe that the activities in Standard 1 constitute minimum thresholds for reasonable care. For example, Berman and colleagues assert: “The assessment of risk involves, at a minimum, attention to the possibility of suicidal behavior through the asking of questions about suicidal thoughts, plans, intent, and actions, in addition to known risk factors” (Ref. 25, p 260). Similarly, Beckson and Penn state that “A good faith psychiatric interview and examination of the patient is required to meet the standard of care. Questioning the patient about suicidal ideation, intent, and plan is required” (Ref. 26, p 17). However, only inquiring about suicidal ideation, plans, and means is “grossly inadequate for defending against allegations of negligence” (Ref. 27, p 3) and “A suicide assessment that focuses solely on the here and now is very likely to fall below the standard of care” (p 3). Finally, in their analysis of treatment failures that expose practitioners to liability, Packman and colleagues\textsuperscript{15} urge clinicians to obtain a thorough self-harm history to minimize liability.
Standard 1 recognizes that a reasonable clinician’s efforts are subject to a patient’s cooperation and to the treatment context. There is no guarantee that the patient will disclose suicidal thinking when asked, and patients may intentionally mislead the clinician to avoid detection; other conditions may interfere with reliable reporting as well (e.g., psychosis or substance intoxication). On the other hand, courts expect clinicians to know more about long-term patients. In *Perez v. United States*, the Court concluded that, in longer treatments, “the provider has (or should have) greater knowledge of a patient’s specific psychiatric status and suicidal intentions and can better prescribe and administer a course of action” (at 120).

**Standard 2: Gathering Data from Other Sources**

*Whenever relevant and possible, the clinician reviews pertinent documentation, makes reasonable attempts to obtain past records, and collects collateral reports from other professionals, family, or significant others.*

The Restatement Third, the widely respected reference in tort law, states that sometimes anticipating harm requires engaging in an effort to fully appreciate present dangers. Courts “take into account the likely benefit in risk reduction the actor could have achieved by endeavoring to gather more information before engaging in conduct, and also the burden the actor would have borne in making such an effort” (p. 33). This bears out in cases involving suicidal behavior: negligence is often found when records have not been obtained or reviewed in part because failing to do so allowed critical information to go undetected. For example, in *Bell v. New York City Health & Hospitals Corp.*, a psychiatrist was found negligent in part because he did not obtain past treatment records, which documented three previous suicide attempts. Similarly, failing to review available records, which contained a history of hospitalization for thoughts of self-harm, sup-
ported a finding of negligence. Thus, courts appear to take the perspective that the burden on clinicians to inform themselves costs little in time and effort, especially when compared with the severity of possible harm to the patient.

Standard 2 includes critical qualifiers (“whenever relevant and possible,” “pertinent,” and “reasonable attempts”). On the face of it, obtaining past records seems a shoe-in for any standard on gathering clinical data. However, courts seem to recognize that what practitioners should know depends on the circumstances, and reviewing records has not always been found to proximately cause injury (for a review of illustrative cases, see Roach, Hoban, Broccolo, Roth, & Blanchard). And the reality of day-to-day practice is messy. Obtaining collateral reports in low-risk situations, for example, is often unnecessary. Higher-risk situations, of course, demand that clinicians be more thorough before formulating a diagnosis and plan. However, even here the reasonableness of a clinician’s efforts to obtain and review records should be judged in the light of the patients’ willingness to sign releases of information, the urgency of the situation (emergency rooms visits, home visits by psychiatric emergency response teams), and the length of clinical contact (e.g., hospitalizations lasting 72 hours). In some cases, obtaining past records quickly is difficult if not impossible.

Even when records are readily available, Standard 2 requires that clinicians review only pertinent records. Of course, what constitutes “pertinent” is not always straightforward. As Rogers et al. highlight: “Do psychiatrists have time to sift through hundreds of pages of documents of patients’ medical records? Do psychiatrists need to obtain records from 1 year ago, 5, 10, or 20? Should just mental health records be obtained? What about from a patient's primary
care provider?” (Ref. 32, p 453). Tellingly, psychiatrists do not commonly request records older than one year for moderate risk patients.³³

Additionally, clinicians must balance the need for information with preserving therapeutic rapport. In the early sessions, when past records are typically requested, rapport is tenuous with difficult and disturbed patients and must be weighed against the intrusion to privacy that patients may experience when pressured to involve collaterals. The matter is simpler when working with children and adolescents, but parental cooperation can be an issue. On the other hand, clinicians must balance confidentiality with their duty to protect. In cases where the clinical picture suggests that collateral information is critical to a complete SRA, clinicians must weigh the risks and benefits of preserving privacy and the duty to protect.³⁴ That said, Simpson and Stacy warn:

“Comments after the fact that one didn't call relatives or prior caregivers for information because of ‘confidentiality’ ring hollow to a jury when it is obvious that the patient was in danger” (Ref. 27, p 188).

Finally, Standard 2 is informed by the common forensic wisdom: “Do not over-rely on patient’s report.”³⁵ Past records and collaterals can resolve discrepancies in the patient’s report or reveal clinically significant behavior. Even courts have opined that relying solely on a patient’s denial of intent is not acceptable.¹⁸

**Standard 3: Estimating Suicide Risk**

*The clinician estimates the degree of suicide risk based on collected information.*

The law expects the reasonable clinician to anticipate harm, that is, to exercise foreseeability. According to the Restatement Third: “Primary factors to consider in ascertaining whether the person's conduct lacks reasonable care are the *foreseeable likelihood* that the person’s con-
duct will result in harm, the *foreseeable severity* of any harm that may ensue, and the *burden of precautions* to eliminate or reduce the risk of harm” (emphasis added, Ref. 6, p 29). The suicide risk estimate is akin to foreseeable likelihood because it summarizes risk data that the clinician can use to anticipate harm. Greater risk indicates more foreseeability. In SRAs, the foreseeable severity of harm is always serious injury or death that can occur as a result of a suicide attempt. Therefore, it is the suicide risk estimate that aids clinicians in determining the burden of precautions they must take to safeguard the patient from suicide.

Courts accept that suicide is not predictable\textsuperscript{36} and that harm is best foreseen by assessing risk. Not only do courts understand what risk factors are (i.e., they frequently describe relative risk, are not causal), they appreciate that a consideration of risk factors is a logical approach to determining the degree of danger “because of the difficulty of tracing exactly whether and how a given action combines with other factors to directly ‘cause’ a particular death” (Ref. 37, at 17). Furthermore, courts grasp concepts such as chronic factors, acute factors, and warning signs (although may not refer to them as such). For example, in *Keebler v. Winfield Caraway Hospital*, the Alabama Supreme Court found that suicide is foreseeable when a person has a “history of suicidal proclivities, has “manifested suicidal proclivities” to the defendant, or was hospitalized for a suicide attempts and treated by the defendant (Ref. 38, at 845).

Standard 4 avoids specifying how clinicians should estimate risk. Estimating suicide risk is an artful exercise in applying scientific knowledge partly because the science of risk estimation for suicide is still young and partly because it will always require clinicians to extrapolate empirical findings based on groups of patients to a particular patient. In addition, we know little about how risk factors combine to elevate risk. To standardize how clinicians describe risk esti-
mates, some researchers have proposed guidelines for rating overall suicide risk$^{39}$ while others have proposed estimating chronic and acute risk levels separately.$^{40}$ Current risk classifications rely heavily on the progression from suicidal ideation to intent to plans, for which research show mixed support,$^{29}$ and they do not yet incorporate imminent warning signs. While existing classification schemes are compelling syntheses of science and clinical wisdom, no scheme has been shown to correlate with suicide attempts or suicides.$^{41}$ Moreover, the clinical estimation of risk is still evolving.$^{42}$ Nevertheless, Standard 3 expects clinicians to assess the degree of suicide risk because the consequences of not doing so are potentially grave.

**Standard 4: Treatment Planning**

*When there is substantial risk of suicide, the clinician formulates and follows through on a treatment plan, the components of which reasonably correspond to the severity of the suicide risk estimate.*

The law views the doctor–patient relationship as one that imposes an affirmative duty, that is an obligation, to protect patients from harm.$^{6}$ As such, when suicide risk is elevated, courts expect clinicians to take reasonable steps to prevent suicide,$^{43}$ regardless of the treatment setting.$^{44}$ As discussed earlier, in determining what preventative responses are “reasonable,” courts expect clinicians to consider the likelihood of harm (degree of suicide risk) together with the gravity of resulting injury (serious self-injury or suicide). More simply, the rule is “the greater the danger, the greater the care” (Ref. 6, p 46). In SRAs, this means that higher suicide risk estimates should result in more intensive or invasive clinical intervention.

As treaters, we regularly say that treatment decisions are based on clinical judgment. To courts, clinical judgment is evidenced by a “balancing test.” For example, in *Johnson v. United
States, the court concluded that “the treating physician must exercise his judgment and balance the various therapeutic considerations together with the possible dangers” (Ref. 36, at 1293). Thus, clinicians are expected to weigh the cost of preventative measures against the benefit they provide, where cost refers to the amount of effort or expense required by the treater to accomplish the preventative step and benefit refers to the degree of risk reduction a particular preventative step is expected to yield. In general, legal scholars believe that, as serious harm becomes more foreseeable, arguments of cost become less defensible. 6 Based on this, common clinical responses to suicide risk—such as hospitalization, communicating risk to family or significant others, means restriction, or ordering close observation—are likely to be viewed as incurring little cost to clinicians in comparison with substantial reduction in risk such responses could produce.

Forensic experts have been less specific with respect to the SOC and treatment planning for at risk patients, likely because it is impractical to address every type of clinical intervention. Given this reality, Standard 4 expects clinicians to employ a common principle in healthcare: prescribe care that is commensurate with the severity of symptoms and risk of future harm (e.g., as heart disease worsens, interventions become more aggressive and invasive). This type of measured response is also widely accepted in the treatment of suicidal thinking and behavior. 45,46

**Standard 5: Documentation**

*The clinician documents the findings of the suicide risk assessment and, when substantial suicide risk exists, the rationale for the selected course of treatment.*

Many court decisions involving patient suicide clearly show that documentation is necessary to prove that reasonable care was provided. In *Abille v. United States*, the court concluded
that a psychiatrist’s “failure to keep contemporary progress notes reflecting his exercise of judgment, and the basis for it, was below the standard of care” and that this was the proximate cause of a patient’s suicide (Ref. 47, at 14; see also Bell v. New York City Health & Hospitals Corp. 20).

In Campbell v. Kelly, 48 the court was skeptical that a psychiatrist’s habit of only documenting “positive” findings was evidence that an SRA was completed. In other words, the absence of notes is not a reliable indicator that an SRA was done. Finally, in Perez v. United States, 18 the court asserted that neglecting to note risk factors for suicide was a deviation from the standard of care in the treatment of a suicidal patient.

Thus, without documentation clinicians cannot establish whether they met any of the previously described standards. As Simpson and Stacy observe: “Since suicide is one of the worst possible outcomes for a psychiatric patient, most juries conclude that if a psychiatrist actually conducted a suicide assessment, he or she surely would have documented it” (Ref. 27, p 186). Because hindsight bias can distort how experts and juries understand clinical events, 49 the clinical record establishes precisely what data clinicians relied on and how they used it to arrive at a suicide risk estimate. The goal is to show that reasoned judgment was exercised not that the suicide risk estimate was “right” or correctly predicted suicidal behavior. 50

**Standard 6: Monitoring**

*The clinician updates the suicide risk estimate when there are clinically significant changes in the patient’s circumstances or condition and reassesses risk at significant treatment junctures.*

As discussed in Standard 3, the law insists that the reasonable person foresees harm. However, legal scholars point out that, as circumstances change, so does the likelihood of harm. 6 Consequently, so long as there is a duty to care, the reasonable person is obligated to monitor the
risk picture. Courts have applied this reasoning to the care of the suicidal patient. In *Perez v. United States*, the court stated: “To the extent that a mental health patient continues to receive care from a provider, the duty to render a proper diagnosis is ongoing” (Ref. 18, at 86). In addition, findings of negligence frequently occur when suicide risk was not reassessed at critical treatment transitions such as psychiatric discharge or decisions to lower safety precautions.47

As numerous experts have pointed out, SRAs are not static: psychiatric symptoms fluctuate, suicidal urges wax and wane, precipitating factors worsen or fade, and new events can improve or exacerbate the clinical picture.25,51,52 Rudd and colleagues recommend that clinicians: “Routinely monitor, assess, and document a patient’s initial and ongoing suicide risk and document interventions for maintaining outpatient safety until suicidality has clinically resolved” (Ref. 53, p 442). Reid goes even further: “A single risk assessment is often not enough to meet the standard of care” (Ref. 54).

**Conclusion**

Any attempt to define standards will naturally be controversial: some experts will view the clinical activities in some standards as excessive while others will assert that key activities were left out. Nor are the probable standards for SRAs that I have offered intended to resolve all ambiguities in defining the standard of care; forensic experts must still study the facts of a case in order to form an opinion about whether care was negligent. My hope, however, is that these probable standards can support objective forensic analysis and, at the same time, give practitioners a legally informed idea of what the competent assessment of risk involves. Ultimately, these may help the protect our field from intrusive legal decisions.
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