

Malpractice & The Suicidal Client

Clients with suicidal intent or behavior are one of the most challenging and emotionally charged issues in social work today.¹ As even seemingly slight clinical errors can trigger enormous legal fallout, the savvy practitioner proceeds with utmost care and preferably with a team of experienced professionals. In many instances, there is no margin for error.

How does malpractice risk arise? In ways both great and small. A distracted social worker may fail to record an entry in a - clinical record; fail to promptly return a telephone call; fail to monitor the progress of one of many clients long after the crisis seems over. Though the greatest risks involve faulty diagnosis and inappropriate treatment, additional factors combine to make for a potential minefield. Since most state laws impose a duty to protect and prevent suicide, liability for wrongful death can be established in numerous ways, among them:

- ◆ Failure to take appropriate and sufficient action to prevent death.
- ◆ Failure to follow the rules and procedures of a setting
- ◆ Failure to provide an acceptable standard of care
- ◆ Errors in judgment about whether to confine a client, in conjunction with negligent assessment and diagnosis.
- ◆ Failure to document activities performed on behalf of the client.

Assessment: The Cornerstone of Risk-Reduction

Multiple factors should be considered when assessing for suicidal risks. -

- ◆ High-risk Group Membership. This includes adolescents, substance abusers, seniors, persons with chronic mental or physical illness, men (especially white men), the unemployed and retired, and those with a family history of suicide.
- ◆ Current Suicide Plan. From the first meeting and continuing as clinically appropriate *throughout* treatment, social workers should assess for suicide plan or suicidal ideation. Key areas to probe include access to and lethality of proposed method, specificity of plan, and proximity of helping resources.
- ◆ History of Attempts. Recent suicide attempts or attempts involving objectively dangerous

means are high-risk indicators. Other red flags include the client's belief that his or her past suicide attempt would succeed and/or that rescue was unlikely.

- ◆ Current Situation. High-risk indicators include recent job loss, death or divorce in the family, and ruminating about episodes of abuse, neglect, or anniversaries of losses.
- ◆ Personality Factors and Mood. Substance abusers, the severely depressed, and clients with borderline personality disorders or psychotic processes are at elevated risk.
- ◆ Physical Conditions. Chronic physical conditions, current physical trauma or disability, and recently diagnosed terminal, disabling or chronic conditions are red flags.
- ◆ Social Supports. As mentioned, suicide risk increases in instances of isolation and/or impulsivity.
- ◆ Past and Current Coping Skills. Clients who use alcohol or other drugs to cope with problems are at elevated risk.
- ◆ Warning Signs. Be alert to depressive symptoms, verbal and behavioral warnings, and emergency status with respect to timing and intervention. Clients determined to be at risk of suicide within the next 24 hours represent an *urgent, time-sensitive* risk.

In summary, the prudent practitioner should follow established procedures, provide referrals for appropriate complementary services, and seek consultation.

Snapshot: Suicide in the United States

In its 2003 report on suicide, the CDC's National Center for Injury Prevention and Control reported:

- ◆ In 2000, suicide accounted for 29,350 Americans deaths. More Americans died from suicide than from homicide.
- ◆ In 2000, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease *combined*.
- ◆ Overall, suicide is the third leading cause of death for young people ages 15-24 and the 11th leading cause of death in the U.S.
- ◆ Suicide rates are highest among Americans age 65 years or older.

Tips for Reducing Malpractice Exposure

Practitioners may reduce their exposure to malpractice action by adhering to sound clinical practices, but should be mindful that a suicide can occur at any time. There is little to no predictability. In determining the type and timing of intervention needed, social workers can also evaluate whether the potentially suicidal client appears to be an emergency with respect to timing or long-term risk.

For clients judged emergency suicide risks, treatment usually focuses on crisis intervention, referral to appropriate complementary services, and voluntary or involuntary hospitalization. For clients deemed long-term suicide risks, ongoing treatment and complimentary services are generally indicated.

Once the practitioner has obtained medical treatment for—and ensured the safety of—the client, the next focus can be on problem-solving interventions. These may include:

- ◆ Guiding the client in an examination of the pros and cons of death so that the client can be more objective in his or her thoughts.
- ◆ Developing an action plan to help guide the client away from suicide.
- ◆ Focusing on examining problems leading to the client’s suicidal crisis.
- ◆ Considering a no-suicide contract.
- ◆ Implementing appropriate follow-up.

It should be noted that research findings conflict as to the efficacy of no-suicide contracts. Moreover, developing such contracts draws on clinical issues beyond the scope of this Practice Pointer. Suffice it to say that no-suicide contracts are in themselves insufficient to protect clients from self-harm and must be part of a comprehensive array of clinical services.

Top 5 Cited Scales for Suicidality:

- ◆ Beck Scale for Suicidal Ideation
- ◆ Reasons for Living Inventory
- ◆ California Risk Estimator for Suicide
- ◆ Los Angeles Suicide Prevention Center Scale
- ◆ Suicide Probability Scale

Note: Administration takes 1.8-3.6 minutes

Source: Bongar, B., et al. (1999). *Risk Management with Suicidal Patients*, Pub Location: Guilford Publications.

For more information on suicide and malpractice risk, please read this consulted resource:

¹ “Prudent Practice: A Guide for Managing Malpractice Risk,” by Mary Kay Houston-Vega and Elane M. Nuehring, with Elisabeth R. Daguio, 1997.

Additional resource. NASW has a practice update on “Minimizing Practice Risks with Suicidal Patients” by Mirean Coleman. (202) 336-0207 Bongar, B., et al. (1999). *Risk Management with Suicidal Patients*, Pub.

Practice Pointers is a service of:

The NASW Insurance Trust
750 First Street, NW, Suite 700
Washington, DC 20002-4241
(202) 336-8387
www.NASWInsuranceTrust.org

Matthew Robb, MSW, writes for the NASW Insurance Trust. Names and case examples depicted in Practice Pointers articles are fictitious. Any resemblance to persons living or dead is coincidental.

Submit questions on practice issues to the NASW Insurance Trust via blawrenc@naswdc.org for appropriate referral. To obtain social work professional liability insurance, call the American Professional Agency at (800) 421-6694 or visit www.americanprofessional.com

Copyright & Reproduction Information

Copyright © 2003 - 2004
National Association for Social Workers Insurance Trust
All rights reserved.

Specific, written (can be e-mail or fax) permission requests are required prior to any reproduction from the National Association of Social Workers Insurance Trust. Except where an author has specifically restricted permission, permission is hereby granted for republication of articles by not-for-profit organizations, journals, and publications; provided publication and credit is given, and a copy of the publication or URL is forwarded to our address below. Include contact name and information with correspondence. This copyright notice is not intended to discourage creating a link to this newsletter on home pages or in Web browsers with bookmarks.

Forward reprinted articles to:

Practice Pointers Editor
NASW Insurance Trust
750 First Street, NE, Suite 700
Washington, DC 20002

OR e-mail: insurancet@naswdc.org OR fax (202) 336-8318

Terms and Conditions of Use

Statements made in this publication are the views of the authors only and do not necessarily represent the views of National Association of Social Workers or its members. Although this publication has been carefully reviewed by staff, no warranty, expressed or implied, is made, or any responsibility assumed by National Association of Social Workers or the National Association of Social Workers Insurance Trust as to the accuracy or applicability of this publication, any use of this publication, or any related material. The fact of distribution by any means shall not constitute any such warranty.