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Suicide Wrongful Death: Standard of Care Problems Involving the Inaccurate Discernment of Lethal Risk When Focusing on the Elicitation of Suicide Ideation

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Abstract : Suicide wrongful death forensic cases are the fastest rising tort in mental health law. It is estimated that suicide-related cases have accounted for 15% of U.S. malpractice claims since 2006. Most suicide-related personal injury claims fall into the legal category of “wrongful death.” Though mental health experts may be called on to address a range of forensic questions in wrongful death cases, the central consultation that most experts provide is about the negligence element—specifically, the issue of whether the clinician met the clinical standard of care in assessing, treating, and managing the deceased person’s mental health care. Standards of care, varying from U.S. state to state, are broad and address what a reasonable clinician might do in a similar circumstance. This fact leaves the issue of the suicide standard of care, in each case, up to forensic experts to put forth a reasoned estimate of what the standard of care should have been in the specific case under litigation. Because the general state guidelines for standard of care are broad, forensic experts are readily retained to provide scientific and clinical opinions about whether or not a clinician met the standard of care in their suicide assessment, treatment, and management of the case. In the past and in much of current practice, the assessment of suicide has centered on the elicitation of verbalized suicide ideation. Research in recent years, however, has indicated that the majority of persons who end their lives do not say they are suicidal at their last medical or psychiatric contact. Near-term risk assessment—that goes beyond verbalized suicide ideation—is needed. Our previous research employed structural equation modeling to predict lethal suicide risk--eight negative thought patterns (feeling like a burden on others, hopelessness, self-hatred, etc.) mediated by nine transdiagnostic clinical factors (mental torment, insomnia, substance abuse, PTSD intrusions, etc.) were combined to predict acute lethal suicide risk. This structural equation model, the Lethal Suicide Risk Pattern (LSRP), Acute model, had excellent goodness-of-fit [$\chi 2(df) = 94.25(47)$***, CFI = .98, RMSEA = .05, .90CI = .03-.06, p(RMSEA = .05) = .63. AIC = 340.25, ***p < .001.]. A further SEQ analysis was completed for this paper, adding a measure of Acute Suicide Ideation to the previous SEQ. Acceptable prediction model fit was no longer achieved [$\chi 2(df) = 3.571$, CFI > .953, RMSEA = .075, .90% CI = .065-.085, AIC = 529.550].This finding suggests that, in this additional study, immediate verbalized suicide ideation information was unhelpful in the assessment of lethal risk. The LSRP and other dynamic, near-term risk models (such as the Acute Suicide Affective Disorder Model and the Suicide Crisis Syndrome Model)—going beyond elicited suicide ideation—need to be incorporated into current clinical suicide assessment training. Without this training, the standard of care for suicide assessment is out of sync with current research—an emerging dilemma for the forensic evaluation of suicide wrongful death cases.

Keywords : forensic evaluation, standard of care, suicide, suicide assessment, wrongful death
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