“Predicting” and Preventing Suicide

written by Richard Leslie | April 2, 2024

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NOTE: The following article was first published on the CPH website in October 2013. It appears below with minor changes. The three topics covered below are likely to arise in a variety of circumstances during the course of one’s practice. These topics are covered superficially here but are intended to trigger further thought and research. State laws vary in fine nuance, so it is important for practitioners to determine how such subject matter is treated in their respective states of practice.

“PREDICTING” AND PREVENTING SUICIDE

I was reading something published by a national organization representing a mental health profession, and in a chapter dealing with client suicide a statement is made to the effect that these mental health practitioners “are not expected to predict suicide” and “are not expected to prevent suicide.” The one page of content dealt primarily with what a therapist should do upon learning that a client has died by suicide, and it basically recommended that the practitioner promptly call his or her professional liability insurance carrier. The above quotes not only caught my eye, but I was a bit uncomfortable with the message possibly sent (inadvertently). While practitioners cannot be expected to reliably “predict” or foretell suicide, competent practitioners are expected to be knowledgeable about the indicators of suicidal behavior.

I think there would be general agreement with the statement that “health care practitioners play a critical role in the *recognition*, prevention, and treatment of suicidal behavior.” Assuming a proper and competent assessment and/or diagnosis, there may be a reasonable expectation that mental health practitioners will be able to “predict” or foresee a suicide – not necessarily with certainty, but perhaps with a strong clinical suspicion. While it is generally recognized that suicide may occur without any prior warning to the reasonably prudent practitioner, it is also recognized that on some occasions a therapist may not properly or competently assess or diagnose the patient’s likely danger to self or to others.

With respect to preventing suicide, I would think that there is a reasonable expectation that once a risk of suicide is identified as an issue to be addressed, therapists are “expected” to prevent suicide by the implementation of appropriate interventions. While no one can guarantee success, even with competent care and sound clinical judgment, some patients may not receive competent care. If negligence is proven, there could be liability for a failure to take reasonable steps to prevent the eventual suicide. Of course, the particular facts involved will determine whether or not a suicide should have been, or could have been, reasonably “predicted” (foreseen) and whether or not the level and kind of treatment provided was appropriate.

In such cases, the therapist's records become very important, if not critical. Expert witness testimony regarding suicide – including its "prediction" and "prevention" – will also be of great importance.

PARENTAL RIGHTS TO ACCESS CHILD'S TREATMENT RECORDS

When a child (under eighteen years of age) is the identified patient and is being treated by a mental health practitioner, what rights do the parents have to inspect, review, or obtain copies of the records of the child? Does the minor's right to confidentiality trump the parental rights to access the records? These interrelated questions may not arise often, but when they do, they present interesting and sometimes troublesome questions for the practitioner. Reference to state law (which varies from state to state) and perhaps to ethical standards (which may also vary from one professional organization to another) is essential to determining the answers to the questions that may arise in a particular situation.

As a general matter, the mandatory and permissive exceptions to confidentiality applicable to the treatment of adults may also be applicable to minors. For example the duties to report child abuse, elder abuse, or dependent adult abuse apply whether or not the patient is a minor or an adult. Once the practitioner has reasonable suspicion or knowledge of any such abuse, a report is required. With respect to dangerous patients, whether the danger is to self or to others, the practitioner may be permitted or required to break confidentiality regardless of the age of the patient.

Access to the minor patient's records by a parent presents a slightly different situation. Because the parent is legally responsible for the overall well-being of the minor child, the parent has a legal interest in the health and treatment of the child. Sometimes, a parent can be informed about the condition or the progress of treatment of their child in general terms, often with the knowledge and consent of the minor. But there are many situations where confidentiality must be maintained and where a request for access from a parent must or should be denied.

There is a statute in California that provides that access to records and information pertaining to a minor child, including, but not limited to medical, dental, and school records shall not be denied to a parent because that parent is not the child's custodial parent. There is some dispute in California as to the meaning of the term "custodial parent," and difficult situations can be presented where a parent with legal and physical custody objects to the therapist allowing access to the other parent who has no legal or physical custody of the child. In such situations, the therapist is usually well-advised to look at another set of laws that govern the right or duty of the practitioner to deny access to the requesting parent.

In California, the law provides that the representative of a minor (a parent or guardian, for example) shall not be entitled to inspect or obtain copies of the records of their minor child if the minor child is allowed under state law to inspect the records. As a practical matter, that means that almost all patients who are twelve years of age or over would control whether a parent could have access to the child's treatment records. Additionally, the law provides that the parent shall not be entitled to access

the minor's records if the therapist determines that such access would have a detrimental effect upon the provider's professional relationship with the minor or the minor's physical safety or psychological well-being. This law also provides that the decision of the health care provider as to whether or not a minor's records are available for inspection or copying shall not attach any liability to the provider, unless the decision is found to be in bad faith.

What about parental access in your state? When may you deny access? When must you deny access? Is there any protection afforded you when such a decision is made? At what age does the minor control whether or not access by the parent is appropriate?

DISCIPLINARY ACTIONS AND FAMILY LAW MATTERS

In many states, disputes between the parties involved in family law matters are more likely to result in a complaint being made against the treating (or evaluating) mental health practitioner than in most other situations. Custody and visitation disputes, especially those in which the therapist or counselor has treated one of the parties or one or more of the children, produce a lot of grist for the disciplinary mill. Hopefully, licensing board and their investigators are cognizant of the fact that an angry parent who was denied legal or physical custody might lash out at a therapist or counselor who may have treated one or more of the parties to the litigation or a child.

My experience has been that many of these complaints go nowhere. But there are some that proceed forward. Those usually involve the practitioner who has provided some form of written report (or a declaration or affidavit) to the court, wherein the therapist appears to be favoring one parent over the other. This "bias" may in fact be true and justified, or it may be the result of inaccurate and improper involvement of the practitioner. In some cases, practitioners go too far in their enthusiasm to help the patient. For example, instead of declaring under oath that the therapist *has been informed by the patient* of the consistent tardiness of the parent with the visitation, the careless or overly enthusiastic therapist simply declares that the parent with visitation *is consistently late* in bringing the child back from weekend visitation.

Therapists commonly get in trouble for making custody recommendations when they have not been hired to conduct a custody evaluation. There is a difference between saying that a person (the client) would make a good custodial parent and saying that the child would be better off if the custody were with the client. Practitioners also get in trouble by writing about (expressing a professional opinion) a person or persons who they have not treated or examined – without stating that their comments are based upon information they have obtained solely from the treatment of the patient and not from the treatment or evaluation of such other person(s). Practitioners must be careful of the representations that they make under oath or otherwise, especially in contested custody or visitation matters!