

# Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines

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Every 17 min, someone in the United States commits suicide. This equates to 83 suicides every day throughout the year (A. R. Roberts & K. Yeager, 2005). Suicide results in approximately 30,000 reported deaths annually. The loss of a patient to suicide is often a feared outcome among psychiatrists, psychologists, social workers, and crisis counselors, especially because the law assumes that in most situations suicide is preventable. Suicide accounts for many of the largest monetary settlements and judgments as well as a large proportion of malpractice lawsuits filed against mental health clinicians. Yet, clinician's often lack sufficient education on the legal aspects of malpractice associated with patient suicide. This article reviews several legal cases in which psychiatrists and/or social workers failed to protect patients. This includes failure to conduct a comprehensive biopsychosocial and lethality assessment, failure to warn of imminent risk of suicide, and/or breach of duty to care standards. Each case presentation concludes with recommendations for actions. Next, the article identifies common allegations made in suicide malpractice lawsuits. Conditions necessary to meet the criteria for a malpractice suit are laid out. The article concludes with the authors' guideline (FIKKE) for managing malpractice risk along with a decision-making flowchart designed to reduce a patient's risk of suicide during the treatment process. [*Brief Treatment and Crisis Intervention* 8:5–14 (2008)]

KEY WORDS: suicide, malpractice lawsuits, duty to care, lethality assessment, risk factors.

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Suicide lethality assessment and risk management of suicidal patients are growing concerns of mental health professionals throughout North America. In fact, a patient's suicidal death and the accompanying malpractice liability

can have devastating consequences to a mental health professional's career. Regrettably, little, if any, training is currently being provided by graduate schools (White, 2002). This article begins with a review of case examples. It highlights some actions that should be taken (DOs), such as conducting an all-inclusive risk assessment. This is followed by a discussion of the key legal issues surrounding malpractice/negligence lawsuits. The article concludes with the introduction of the FIKKE guideline to avoid a malpractice/negligence lawsuit.

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### ***Risk Assessment/Management***

What exactly is risk assessment for suicide and what is its importance? Risk assessment examines a person's suicide potential and ways to effectively manage such peril (Berman, 2006).

There are so many well-known suicide assessment instruments such as the Beck Hopelessness Scale, Beck Depression Inventory, Scale for Suicide Ideation—Worst Point, Lifetime Parasuicidal Count, SAD PERSON Scale, Linehan Reasons for Living Scale, Suicide Potential Lethality Scale, and many others. One would think that assessment of suicidality would be a simple task. This simply is not the case. Dr. Douglas Jacobs (American Psychiatric Association [APA], 2003), former chair of the APA practice guideline on treatment of patients with suicidal behaviors, reports: Data indicate that 50% of individuals who complete suicide are in psychiatric treatment at the time, 10% are inpatients, and 5%–10% are posthospital discharge. Douglas also reports that with regard to an analysis of records of 100 patients who committed suicide in a hospital, 77% denied suicidal intent in their last communication with staff. One possible explanation of the patient's change is the frequent ambivalence expressed by patients. At intake assessment, patients or their family members frequently report suicidal thoughts, threats, and/or gestures. However, because we often have two different or paradoxical thoughts at almost the same time, many patients decide after several hours in a busy hospital emergency room that they would be more comfortable going home and controlling their own decisions and/or they want to live for an upcoming family event. For example, a close family member's high school or college graduation may only be 6 months away. Inadequate lethality assessments and other concerns related to patient assessment, reassessment, orientation of staff regarding suicidal risk measures combined with inadequate staffing levels, and infrequent patient observations

contribute to inpatient psychiatric patient suicides. Additionally, the Joint Commission on Accreditation of Hospital Organizations reports that there are a significant number of suicides in general hospital settings. Despite all the risk measures, it is necessary to develop a Practice Guideline for the Risk Assessment and Treatment of Patients with Suicidal Behaviors that combines practice knowledge, experience, and evidence and takes into account patient rights.

Psychiatrists, social workers, and psychologists sometimes lack the training in assessing the degree of suicidality and conducting a lethality assessment. According to the APA (2003, p. 23) Practice Guideline for patients with suicidal behaviors:

If the patient has developed a suicide plan, it is important to assess its lethality. The lethality of the plan can be ascertained through questions about the method, the patient's knowledge and skill concerning its use, and the absence of intervening persons or protective circumstances . . . .

We build on the APA (2003) Practice Guideline which is not intended to serve as a standard of care. The APA guidelines have been developed by psychiatrists who are highly experienced clinical practitioners, combined with researchers and academicians. The guideline consists of three parts (Parts A, B, and C). Part A addresses Assessment, Treatment, and Risk Management Recommendations. This includes key recommendations of the guideline and codes each recommendation according to the degree of clinical confidence associated with the recommendations. Additionally, there is a discussion of assessment of the patient including consideration of factors that may impact suicidal risk. Recommendations are made with regard to psychiatric management, treatment modalities, as well as for documentation of care and potential risk management issues. Part B, of

the guideline outlines background information, for example, natural history, epidemiology, and course, as well as a review of currently available evidence. Part C of the guideline is dedicated to drawing from the previous sections, summarizing recommendations, and outlining areas where additional research is required to advance the data, knowledge, and practice approaches in addressing high-risk behaviors. We support and build upon the APA guideline and are not trying to replace it.

The suicide ideation and assessment flowchart in this article takes into account several critical warning signs (Figure 1). The following warning signs are adapted from the chapter in the third edition of the *Crisis Intervention Handbook* by Roberts and Yeager (2005, pp. 41 and 45):

- family member reports on drastic behavior change in patient (e.g. banging his head against the wall, or barricading himself in his room for an extended period and not coming out for meals or the bathroom);
- family member reports on patient's suicidal statement;
- patient gives away prized possessions;
- patient indicates that they have a firearm in their home and they exhibit poor judgement;
- patient indicates depression symptoms;
- patient expresses suicide ideation;
- patient has a suicide plan;
- patient is agitated and exhibits imminent danger to self or others;
- psychotic patient exhibits command hallucinations related to harming self or others;
- patient is intoxicated or high on illegal drugs and acting in an impulsive manner.

It is the goal of this article to address issues related to risk assessment and management measures while devising ways to instruct mental health professionals that would safeguard them against malpractice suits. The authors of this article chose a unique and innovative ap-

proach. We developed specific actions "to do." How is it unique and innovative? What does it do that the APA guideline does not do? The following section answers these two questions by presenting concise summaries of cases from which a list of practical "DOs" will be derived.

### Case Examples

1. *Hanging by a Thread* (Roberts & Jennings, 2005)—After watching her husband express hallucinations (thought that his testicles were disappearing), sudden major changes in behavior, such as banging his head against the wall, heavy pacing around in underwear, as well as enunciating a suicide threat of wanting to end his life through hanging, a concerned wife takes her husband to the emergency room of a private hospital. The patient is soon transferred to the nearest city hospital with a mental health intake unit, and the mental health technician's completed form is faxed ahead of time to the city hospital's intake unit. This form notes that Mr. Banach was a danger to himself because he mentioned the desire to end his life through hanging. The patient was then examined and interviewed at the city hospital by an attending physician, Dr. Dang, and later interviewed on the phone via a 20-min translated phone conversation with a social worker, Chester Scott. Within 1 hr, the attending physician and social worker allow the family to take the patient home, stating that he was sexually dysfunctional due to "drinking problem" (Roberts & Jennings, 2005, p. 2), further advising that he should receive follow-up treatment at an outpatient community clinic. Unfortunately, the social worker and physician failed to make a proper diagnosis of psychosis, depression, and high suicide risk; failed to

give the family proper warning of risk of suicide; as well as ensure the patient's safety once he left the hospital. The patient hung himself at approximately 2 a.m. a few hours after his midnight discharge from the hospital (Roberts & Jennings, 2005).

The social worker attempted to defend himself by negating his liability due to his position as a social worker, passing it on to the doctor. The court denied his defense, explaining how the social worker and doctor worked as team, having equal share in the responsibility. Both, doctor and social worker were found liable (Roberts & Jennings, 2005).

- ✓ DO: diagnose properly (adequate assessment—especially suicide).
    - Gain an understanding of client's hopes and plans for the future, levels of depression and anxiety, psychotic and delusional thoughts, and family members' reports of suicidal threats or gestures (Roberts & Jennings, 2005, p. 4).
  - ✓ Evaluate properly (*please refer to flowchart*).
  - ✓ Be aware of the nine most serious warning signs for suicide (these are listed earlier in this article).
  - ✓ Be knowledgeable on the standard of care (provide a translator to inform not only the patient, but the family of important information).
  - ✓ Become aware of your role in the team.
  - ✓ Take appropriate action to inform the family of patient's status.
  - ✓ Don't take family's concerns lightly.
  - ✓ Be suspicious of highly unusual behavior.
  - ✓ Take higher precautions if patient demonstrates an active suicide plan.
2. *Gaido v. Weiser* (1988/1989)—a patient with a history of severe depression and

anxiety, previously diagnosed as having multiple sclerosis, and having attempted suicide was released from his inpatient treatment, being required that he continued psychiatric treatment. The appointment to meet with a new doctor was scheduled for 6 days after his release; in the meantime, the patient began demonstrating anxiety symptoms that were very similar to what he had experienced in the past, prior to hospitalization, including a very unusual one: excessive drinking. Concerned, the wife called the new doctor (Dr. Weiser) and asked that he see her husband that same day. The doctor refused the wife's request, given that the patient continued taking his medication—even though he did not check what medication had been previously prescribed. The wife continued trying to schedule an earlier appointment, at one point, the Dr. agreed to prescribe something "to take the edge off" (p. 15) while he maintained his position of not being able to see the patient before the scheduled appointment. Patient's body was found on a riverbank, the autopsy found a large amount of water in his stomach, and a 0.23% alcohol in his blood, it was then concluded that the patient drowned, and the "cause of death" was "accident." The wife expressed that the doctor did not meet the appropriate standards of care and was negligent in prescribing the drug Tranxene to her husband, "proximately causing decedent's death." The doctor denied (*Gaido v. Weiser*, 1989) "breach[ing] the proper *duty of care*":

legal obligation imposed on an individual requiring that they exercise a reasonable standard of care while performing any acts that could foreseeably harm others (APA, Practice Guideline, 2003)

further stating that if his behavior was found to be negligent, it would not be the “proximate cause”—an event that is legally sufficient to document liability resulting from a legally recognizable injury to be held the cause of that injury (Black, 1999, p. 234) of decedent’s death (*Gaido v. Weiser*, 1989). According to *Black’s Law Dictionary*, negligence is defined as “an act or omission that is considered in law to result in a consequence so that liability can be imposed on the actor” (Black, 1999, p. 234). The court found negligence on the part of the psychiatrist due to his failure to acquire the patient’s medical history and the fact that he prescribed a medication in its absence. The court found the doctor negligent based on the “failure to obtain the patient’s hospital records, as well as his failure to ascertain what medication the patient had previously been prescribed” (Baergar, 2001). One would do:

- DO: Obtain the patient’s history (hospital records, medications previously prescribed, current medications, etc.) before making judgments, especially prior to prescribing medication.

*Abille v. United States* (1980)—after being prescribed Reserpine—a drug for the control of high blood pressure—the patient began experiencing depressive symptoms (often a side effect of Reserpine) and suicidal thoughts and decided to admit himself into a hospital. His medical history was taken during intake by a psychiatrist, who noted psychomotor retardation, suicidal ideation, and sleep disturbances (*Abille v. United States*, 1980).

He later concluded that the patient was suffering from “depressive neurosis,” “hypertension,” and “reactive depression to Reserpine” (*Abille v. United States*, p. 2). All patients were given status levels. New patients were usually granted S1 status—the most highly restrictive—only allowing patients to move with an accompanying staff member. Four days after his

admission, Abille was allowed to attend mass, shave, and go to mass unattended—granting him S2 status, which was generally given to patients who were not thought to be of suicidal risk. He was found dead shortly after he was given the razor. According to the autopsy report, he took his own life (*Abille v. United States*, 1980).

Although Dr. Hipolito testified that he did change Abille’s status to S2, there was no written record of it. The nurses acted based on the assumption of this presumed change. Thus, the court had to decide if the defendant met the principles of due care in his attempt to safeguard Abille against his own self-injurious behavior (*Abille v. United States*, 1980). In order to sustain the burden of proof, in other words, to prove the allegations enunciated by the court (for full list refer to *Abille v. United States*, p. 3), three questions were raised:

Did Dr. Hipolito in fact change Abille’s status?

If he did change it, did he exercise due care in doing so?

If he failed to exercise due care, was his negligence a proximate cause of Abille’s death? (*Abille v. United States*, pp. 3–4).

The court found that by allowing the patient to leave the ward by himself, the nurses acted below the standard of care. Court further noted that the psychiatrist’s decision to change Abille’s level was within the standard of care; however, the way through which he did so was not. There were no notes or any records that could serve as a documentation of his decision-making process. Dr. Hipolito was found liable for his failure to “describe accurately and fully in his report of the events and medical orders everything of consequence that he did and which his trained eye observed during the inpatient stay” (*Abille v. United States*, p. 8).

- ✓ DO: keep an all-inclusive record, from the patient's status to reasons behind choosing a certain decision.
- ✓ Avoid making assumptions—make sure there are documented reasons and notes prior to following an order.

*Stepakoff v. Kantar* (1984–1985)—The wife of a patient diagnosed as “manic-depressive psychotic” (Stepakoff, p. 2) alleged that her husband's psychiatric doctor failed to let her know of his suicidal status and to implement adequate arrangements for her husband's safety (*Stepakoff v. Kantar*, 1984–1985).

Experiencing some marital difficulty, the wife goes away letting the patient—Mr. Stepakoff—know that he must be out of the house when she gets back and also informing the doctor of the situation—the doctor tranquilizes the wife stating that her husband should be fine. The psychiatrist was aware of his patient's suicidal tendencies, but believed that the patient had strong coping mechanisms and because he had been treating the patient for 15 months, he also thought that he had established a close and strong therapeutic relationship with the patient, which would deter Mr. Stepakoff from attempting suicide or from making any major decisions without contacting him first (*Stepakoff v. Kantar*, 1984–1985).

The psychiatrist had plans to go on a weekend vacation 2 days after the patient's wife had left him. He made arrangements for the patient to continue treatment with another psychiatrist while he was away and agreed to give him a follow-up call every night (*Stepakoff v. Kantar*, 1984–1985).

Prior to going on vacation, he had an emergency meeting with the patient, during which he noted, a “question of whether he will make it over the weekend” (*Stepakoff v. Kantar*, 1984–1985, p. 2). During his statement to the court, he explained this question as not being a suicidal concern, but rather,

Whether he would be able to carry out the activities that he and I outlined, or whether the type of thing that happened to him just preceding his psychiatric admission to Newton-Wellesley [in 1974] would occur . . . it was that type of regression and inability to function that I was questioning (*Stepakoff v. Kantar*, 1984–1985, p. 2).

The court stated how the psychiatrist has a duty to his patient, not to third parties. Thus, the psychiatrist was not found negligent due to the cautious treatment plan he developed in conjunction with the patient, as well as the fact that the patient did not meet the legal criteria to be hospitalized involuntarily at the time (*Stepakoff v. Kantar*, 1984–1985).

- ✓ DO: Be familiar with the legal criteria for involuntary commitment.
- ✓ If you need to be absent, make proper arrangements for patient to continue treatment.
- ✓ Follow through with plans/stand behind decisions (if you tell the patient you'll call, than do so).
- ✓ Document thoughts.
- ✓ Reread notes—explain/document certain “incriminating” remarks.

*Bates v. Denny* (1990)—Mr. Bates, a 33-year-old male was brought to the emergency room of a hospital, complaining of pain in his ribs due to falling from a flight of stairs. Several cuts and scratches were found on his wrist during examination, which he explained as being “cat scratches” (*Bates v. Denny*, 1990, p. 1). The patient's mother, Irene Bates, was a relative of the emergency room physician and elaborated on her son's psychiatric and hospitalization history, including two recent suicide attempts—overdose on sleeping pills and

shooting himself in the abdomen—concerned that her son was suicidal, she asked for his hospitalization. She further stated that Mr. Bates had stopped taking his medication and expressed a desire to kill himself through usage of a gun. However, when questioned, he contested being suicidal and did not agree to being hospitalized (*Bates v. Denny*, 1990).

#### Assessment and Testing

Dr. Newman did perform a mental status evaluation on the patient, and other than noting his slurred speech and discontent with family's insistence on hospitalizing him, his behavior was rather normal. The decision to send the patient home was made based on the phone conversation he had with the patient's most recent psychiatrist, also the patient was not thought to be depressed or psychotic, and the family was to keep close watch, ascertaining that he did not obtain access to a weapon, further stating that involuntarily hospitalizing the patient, would perhaps be counterproductive (*Bates v. Denny*, 1990, p. 3). Mr. Bates died the next morning from "a self inflicted contact gunshot wound to the right temple" (*Bates v. Denny*, 1990, p. 1).

Three psychiatrists provided expert testimony. To summarize arguments that found the psychiatrist negligent were based on the patient's "chronically suicidal" (*Bates v. Denny*, 1990, p. 4) status. During the testimony, one of the experts stated that because the patient posed a serious threat to himself, the best way to safeguard him was to keep him under a close watch within the safe and highly monitored atmosphere of a hospital. He further stated that if the patient does not demonstrate suicidal ideation, it is up to the mental health professional to make a judgment call as to the truthfulness of the patient's word, perhaps alluding to the doctor's improper judgment (*Bates v. Denny*, 1990).

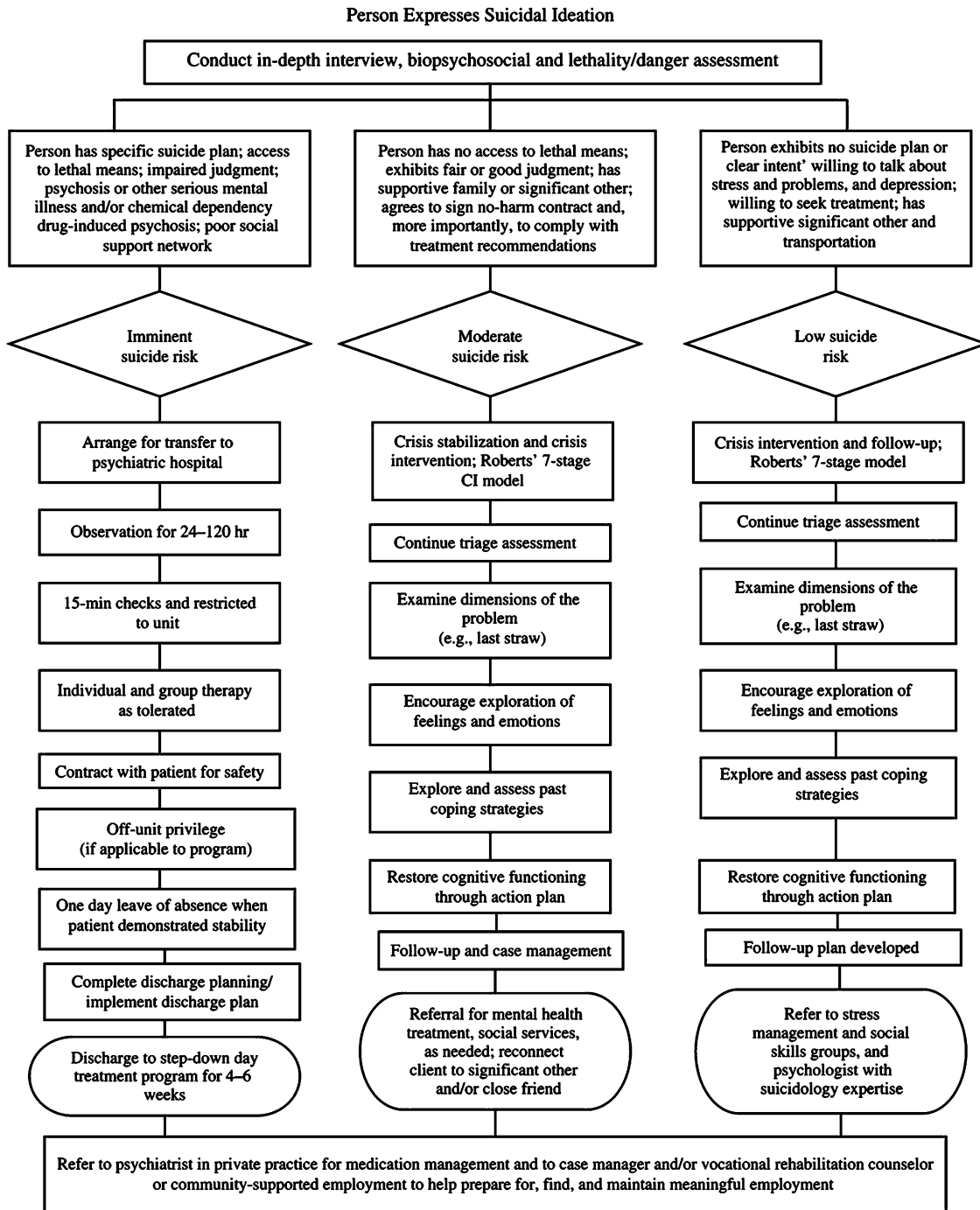
Arguments against assigning culpability to the psychiatrist were slightly similar, also rely-

ing on the elaboration of the patient's chronically suicidal status.

A chronically suicidal person is one who has a suicide potential over a long period of time with periods of remission alternating with acutely suicidal states (*Bates v. Denny*, 1990, p. 4).

Expert testimony as well as the court noted that the patient was in his remission state, not acutely suicidal, and did not express any psychotic or suicidal signs; thus, it was within the standard of care to allow him to leave. In other words, one cannot maintain a chronically suicidal patient locked up indefinitely. Furthermore, the doctor's actions did not demonstrate a breach in the standard of care due to the fact that the doctor scheduled a follow-up appointment, was aware of the patient's family and clinical history, and also made arrangements to inform the family of the patient's needs. Also, because the patient had a history of being resistant to treatment, involuntarily retaining him would also make his treatment worse. And finally, in expressing the conditions for involuntary hospitalization "whether the patient is suicidal, homicidal or gravely disabled" (*Bates v. Denny*, 1990, p. 5), because the patient did not demonstrate any of these signs, the rule of the "least restrictive" judgment comes into play. Thus, the psychiatrist was found to have acted within the standard of care.

- ✓ DO: obtain patient's clinical and family history.
- ✓ Make arrangements for follow-up appointments.
- ✓ Be knowledgeable on the necessary conditions for involuntary hospitalization.
- ✓ Be aware of the rule of the "least restrictive environment."
- ✓ Think decisions through thoroughly.



**FIGURE 1**  
 From "Lethality Assessments and Crisis Intervention with Persons Presenting with Suicidal Ideation," by A. R. Roberts and K. Yeager, 2005, in A. R. Roberts (Ed.), *Crisis Intervention Handbook: Assessment, Treatment and Research* (3rd ed.). New York: Oxford University Press.



## **Malpractice and Negligence**

In legal terminology, malpractice is classified as a tort action. “Tort” is a civil wrong committed by one individual (the defendant) that caused some injury to another individual (the plaintiff) (Packman and Harris, 1998, pp. 150–186).

Negligence is “the failure to exercise the standard of care that a reasonably prudent person would have exercised in the same situation” (Black, 1996, p. 1405). The “standard of care” is “the degree of care that a reasonable person should exercise,” thus differing from situation to situation (Black, 1996, p. 589). Malpractice is frequently described as “professional negligence,” referring to negligence or incompetence on the part of the professional; specifically, “a negligent act committed by a professional that harms another” (Roberts and Jennings, 2005, p. 5). There are two primary areas of focus: an act of commission (i.e., mental health professional doing something that should not have been done) and an act of omission (i.e., mental health professional not taking appropriate action given presenting risk factors) (Roberts and Jennings, 2005, pp. 1–10).

In regards to malpractice suits, the plaintiff must demonstrate that their case against the defendant meets these conditions:

- Action Based Elements of Proof
- Duty of care was owed by the professional to the plaintiff;
- The professional violated the applicable standard of care—breach of duty;
- The plaintiff suffered a compensable injury; and
- Causation, that the plaintiff’s injury was caused in fact and proximately caused by the defendant’s substandard conduct. (Roberts and Jennings, 2005, pp. 1–10)

In addition to knowing the conditions that must be met in a malpractice suit, it is also im-

portant for a practitioner to be familiar with the typical allegations made in a malpractice suit filed in a case of suicide.

## **Top Eight Complaint Allegations**

Extracted from the work of Packman, Pennuto, Bongar, and Orthwein (2004)

- Failure to predict or diagnose the suicide.
- Failure to control, supervise or restrain.
- Failure to take proper tests and evaluations of the patient to establish suicidal intent.
- Failure to medicate properly.
- Failure to observe the patient continuously, (24 hrs.) or on a frequent enough basis (e.g. every 15 minutes).
- Failure to take an adequate history.
- Inadequate supervision or failure to remove dangerous objects, such as a patient’s belt.
- Failure to place the patient in a secure area.

## **Guidelines to Avoiding Malpractice/ Negligence Lawsuits (FIKKE Model)**

In order to obtain a more in-depth understanding of the issues, as well as employ the best precautionary actions against a malpractice/liability suit, the authors offer the following guidelines.

### **FIKKE Model of Malpractice Suits.**

*Familiarize* yourself with the common allegations in negligence/malpractice suits.

*Implement* an all-inclusive Risk Assessment Strategy—please refer to Roberts’ and Yeager’s flowchart (reprinted in this article).

*Know* suicide warning signs and legal terminologies and their meanings (meanings of important terms such as proximate cause, burden of proof, negligence, malpractice).

*Keep* the Dos in mind.

Enhance understanding through case examples.

## Conclusion

The overriding goal of our suicide prevention work is to save lives. However, even the most competent professional cannot always prevent a patient's suicide, especially in the small number of cases where there are no warning signs. Cases proceed to court only if the suicide was reasonably "foreseeable and preventable" (VandeCreek & Knapp, 1989). This article hopes to decrease the odds of being found negligent or liable for a patient's suicide while also preventing suicides by providing clinicians with a Dos checklist and decision flowchart, for improving assessment and patient management. It identifies specific suicide risk practices and familiarizes clinicians with the malpractice aspects of their fiduciary duty to protect those under their care.

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