Although FNHRA does create specific regulatory processes to address violations, § 1983 lawsuits can bring about more immediate and targeted relief while also providing financial compensation to harmed plaintiffs. As the AARP, *et al. amici curiae* brief points out in supporting the Talevskis, many states have backlogs of uninvestigated nursing facility complaints, so it is often difficult for agencies to address possible rights violations in a timely manner (Available from: https://www.supremecourt.gov/DocketPDF/21/21-806/238626/20220923113017947_21-806%20Amici%20Brief%20AARP%20Final.pdf. Accessed August 30, 2023).

Section 1983 action can lead to injunctive relief; that is, courts may require a nursing facility to immediately address a possible FNHRA violation even prior to issuing a final judgment in the case. Private lawsuits can also provide financial compensation to plaintiffs who have experienced harm. On the other hand, the primary mechanism for the federal government to enforce violations of FNHRA or other spending clause legislation is through withholding federal funding, which in practice could make it more challenging for states to become compliant and result in a reduction of services to vulnerable individuals (Shen W S. Courts split on whether private individuals can sue to challenge states' Medicaid defunding decisions: considerations for Congress (Part II of II). Congressional Research Service. 2019 July 3. Available from: https://sgp.fas.org/crs/misc/LSB10321.pdf. Accessed August 30, 2023).

Health & Hosp. Corp. focused on FNHRA provisions, but its holding extends to the Medicaid Act more broadly, as well as other federal spending clause legislation, such as the federal Supplemental Nutrition Assistance Program (SNAP) or the Children's Health Insurance Program (CHIP). The decision in *Health & Hosp. Corp.* preserves a crucial mechanism for beneficiaries of federally funded programs to enforce their rights.

Legal Foreseeability and Suicidal and Homicidal Risks

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Mental Health Providers Owe Duty of Care in Case of Patient Suicide

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In *Smits v. Park Nicollet Health Servs.*, 979 N.W.2d 436 (Minn. 2022), the Supreme Court of Minnesota held that a health care provider owed a duty of reasonable care to a patient who died by suicide, and that a medical provider does not assume a duty of care to the family of a patient unless there is evidence indicating the providers should have foreseen their medical advice would influence the family's actions.

Facts of the Case

Smits involves a familicide-suicide that occurred in 2015. Brian Short, a 45-year-old married man with three children, sought treatment for anxiety and depression from several providers at Park Nicollet Health Services (PNHS), a medical group in Minnesota. Despite receiving treatment, Mr. Short murdered his wife and three children before taking his own life.

Mr. Short initially visited a PNHS urgent care clinic on June 16, 2015, where he complained of tightness in his chest, difficulty sleeping, and work-related stress. He was evaluated by a physician assistant, who diagnosed him with anxiety and prescribed alprazolam. Two days later, he saw his primary care physician (PCP), also at a PNHS clinic, who prescribed the antidepressant sertraline to address low mood and weight loss. On June 27, Mr. Short presented at PNHS urgent care with worsening sleep difficulties and was prescribed lorazepam and zolpidem. On July 6, he saw his PCP again and reported continued anxiety, occasional panic attacks, and continued unintentional weight loss. His PCP increased sertraline to 100 mg, stopped zolpidem, started trazodone, and referred him for psychotherapy. On July 15, Mr. Short saw an advanced practice registered nurse (APRN) who administered the Patient Health Questionnaire-9 (PHQ-9). He scored 23 of 27 and received a diagnosis of "major depression, single episode, severe, without psychosis" (*Smits*, p 442). For

the first time, "[h]e admitted some idle thoughts of suicide but specifically denied 'any plan or intent'" (*Smits*, p 442). It was considered to be "too early" for a medication change, but he was referred to "counseling."

On July 16, Mr. Short attended his first appointment with a PNHS licensed social worker, during which he "was separately asked about, and denied having, any 'suicidal/homicidal ideation, intent or plan'" (*Smits*, p 442). During this visit, Mr. Short scored 23 on the PHQ-9, including acknowledging "a few" days in which he had thoughts of hurting himself or that he would be better off dead. On July 28, Mr. Short called PNHS and told a nurse the prescribed medication was not working. The APRN who had met with Mr. Short on July 15 directed this nurse to increase sertraline to 150 mg over the phone. On August 4 and 12, Mr. Short attended two more psychotherapy sessions where he "continued to report anxiety and depression, though he denied suicidal/homicidal 'ideation, intent, or plan'" (*Smits*, p 442). The PHQ-9 was not administered during either appointment; Mr. Short arrived late on August 4, and there are no records for the appointment on August 12. On August 14, Mr. Short met with the APRN for "approximately 15 minutes," reported "unchanged or worse" symptoms except for improvement in sleep, and "denied suicidal/homicidal 'ideation, intent or plan'" (*Smits*, p 442). Mr. Short's PHQ-9 score was 20 and included acknowledging "several days" of thoughts of self-harm or being better off dead. Sertraline was switched to escitalopram with a follow up visit in four to six weeks. Mr. Short rescheduled his August 27 psychotherapy session to September 10, but on or around the date of the rescheduled appointment, after buying a second shotgun (he owned one which was stored at home), he shot his wife, children, and then himself. All parties died from the gunshot wounds.

This wrongful death action was filed against PNHS by the trustee of Mr. Short's next of kin, alleging that PNHS's negligent treatment caused the tragedy. The trustee presented expert testimony claiming that PNHS deviated from the standard of care when treating Mr. Short. The experts pointed out various errors, including failure to educate Mr. Short about the black box warnings for sertraline, and not involving Mr. Short's family in monitoring his behavior. They alleged inadequate time was spent on Mr. Short's evaluation and treatment, and inappropriate medication management. They claimed that alternative treatments were not considered despite Mr. Short's poor response. The trustee's witnesses opined that Mr. Short's profile of being the "senior male and sole bread winner of his household" (*Smits*, p 444), having worsening treatment-resistant depression, and owning a firearm, should have warned PNHS of the risk of familicide-suicide as such individuals might develop delusions of ruin.

The district court granted PNHS's summary judgment motion, finding PNHS did not owe a duty of care to Mr. Short or his family members because there was no evidence of a custodial "special relationship" between PNHS and Mr. Short. The court also found Mr. Short's actions were unforeseeable as there were no prior threats of violence or past incidents of violent behavior. The court did, however, deny PNHS's summary judgment motion as to causation, finding there were genuine problems of material fact in dispute.

The court of appeals reversed the district court's decision, ruling PNHS owed a duty of care to Mr. Short because he was a patient, regardless of whether he was under the custody or control of PNHS. The court of appeals also reasoned PNHS might have owed a duty of care to Mr. Short's family members if harm to them was a foreseeable risk of the alleged departures from the standard of care.

Ruling and Reasoning

The Supreme Court of Minnesota was divided; the majority concurred in part with Justice Hudson's opinion, Part 1, and in part with Justice Anderson's opinion, Part 2.

Part 1 of the court's opinion held that a mental health provider is obligated to exercise reasonable care toward its patients, even if it lacks complete control over the patient's actions, thus rejecting PNHS's argument to the contrary, citing *Becker v. Mayo Found.*, 737 N.W.2d 200 (Minn. 2007). The *Becker* court held a health care provider liable for failure to take preventive action to avert specific injury, even though the injury was caused by a third party's intentional wrongdoing outside the provider's control. The court emphasized that the duty of care for mental health treatment should not be narrowed and should be held to the same standard as any other health care decisions.

Part 2 of the court's opinion reversed the court of appeals' decision to remand for trial on the matter of

foreseeability of the death of Mr. Short's wife and children, finding the harm suffered by the family members fell beyond the scope of the duty owed by PNHS. There was no evidence suggesting Mr. Short's wife and children were patients of PNHS, nor were they in contact with PNHS health care providers. The court also rejected the argument that PNHS created a foreseeable risk of harm to Mr. Short's family by "fail[ing] to do more." The court emphasized foreseeability is a key factor in determining duty and found there were no warning signs or prior history of violent behavior which would have made Mr. Short's actions foreseeable. The court held that Mr. Short's familicide was unforeseeable as a matter of law.

Discussion

The *Smits* court set new precedent in Minnesota, holding mental health providers can be liable for failure to prevent a patient's death by suicide, even if the patient is not in the provider's custody.

According to Obegi, the legal standard for suicide risk assessment (SRA) and response is known to be "ambiguous." Obegi addressed this topic, outlining several crucial considerations related to information gathering, assessment, formulation, treatment, documentation, and follow-up (Obegi JH. Probable standards of care for suicide risk assessment. *J Am Acad Psychiatry Law.* 2017 Dec; 45(4):452-9).

In this case, the *Smits*' experts opined that PNHS did not follow the standard of care when treating Mr. Short. According to the facts set forth, we know Mr. Short did not respond well to his treatment. We also know his clinical interview reports regarding suicidal ideation were not consistent with his responses on the PHQ-9. The extent of assessment for suicide risk is not known.

An SRA following Obegi's framework goes beyond inquiring about suicidal ideation and includes additional information gathering related to changes in functioning, mood, and behavior, both from the patient and collateral sources. This information is then utilized to estimate suicide risk based on a constellation of factors, which informs treatment planning and monitoring, all of which is documented, and later reviewed and updated during subsequent patient encounters. Collateral information gathering may not be practicable in all cases, but a comprehensive approach and documentation of efforts in complex or ambiguous cases is well-advised.

One of the greatest challenges for mental health providers is making judgments about future behavioral risks. This process is complex, multifaceted, and imperfect, but begins with following risk assessment strategies which are in accordance with the standards of care in one's jurisdiction, and thoroughly documenting that one has done so.

In addition to the obvious treatment and liability concerns, as Justice Anderson noted, problems related to foreseeability need to be carefully considered so as not to allow mental health stigma to influence standards or judgment. There is a risk that patient care will be dictated by liability concerns and biases regarding mental illness, instead of patient needs, which can increase mental health stigma and deter help seeking.

Considerations in Determining Intellectual Disability

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Review of IQ Scores Remains Part of Alabama's Standard for Determining Intellectual Disability

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In *Ferguson v. Commissioner*, 69 F.4th 1243 (11th Cir. 2023), the U.S. Court of Appeals for the Eleventh Circuit considered Thomas Dale Ferguson's *habeas corpus* petition to overturn his death sentence, claiming ineffective assistance of counsel and intellectual disability (ID). After reviewing the record, including psychological testing and Mr. Ferguson's IQ scores from childhood and adulthood, the Eleventh Circuit found that neither claim was supported and affirmed the lower court's denial of the *habeas* petition.

Facts of the Case

In July 1997, Thomas Dale Ferguson and four codefendants stole a truck to use as a getaway vehicle