



# Legal and Liability Issues in Suicide Care

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# Moderator

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# Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention



The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.



# #zerosuicide

@SarahABernes

@ZSInstitute

# WHAT IS ZERO SUICIDE?



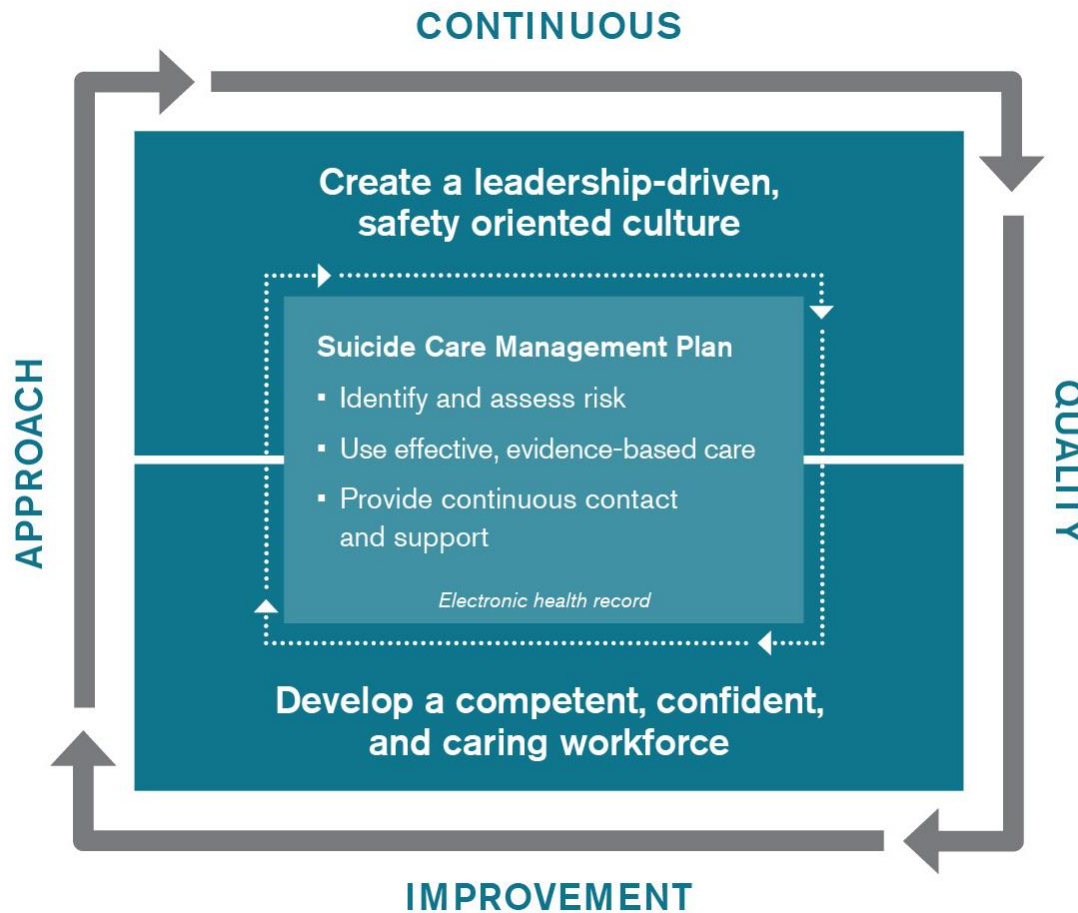
# Zero Suicide is...

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- Embedded in the *National Strategy for Suicide Prevention and Joint Commission Sentinel Event Alert #56*.
- A focus on error reduction and safety in health care.
- A framework for systematic, clinical suicide prevention in behavioral health and health care systems.
- A set of best practices and tools including [www.zerosuicide.com](http://www.zerosuicide.com).

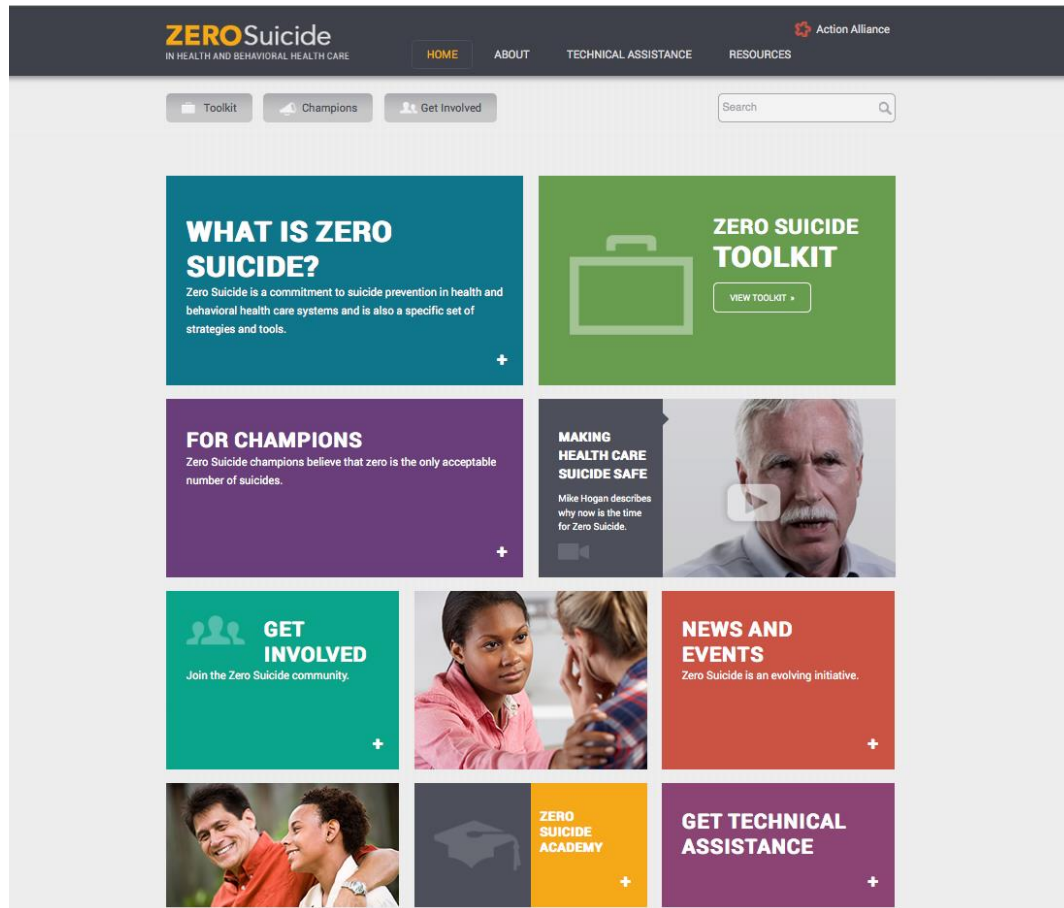
# Elements of Zero Suicide

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# ZeroSuicide.com

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# Contact

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## **Zero Suicide**

Suicide Prevention Resource Center

Education Development Center

[zerosuicide@edc.org](mailto:zerosuicide@edc.org)

202-572-5361

# Learning Objectives

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By the end of this webinar, participants will be able to:

- 1) Identify misconceptions related to provider liability in litigation involving patient suicide.
- 2) Describe suicide care practices that are of particular importance in liability cases.
- 3) Explain system or organizational level improvements to suicide care that can enhance an organization's abilities to deliver quality care and minimize liability concerns.

# Presenters

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**Skip  
Simpson**



**Lanny  
Berman**



**Susan  
Stefan**

# Presenter

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**Skip Simpson, J.D.**

Zero Suicide: Fear not-just do it

# Definition of Liability

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- There are 4 elements to a medical malpractice case: **duty, breach of duty, which proximately causes damage.**
- The plaintiff proves the duty and breach elements by showing that the defendant's act or omission fell below the standard of care and, therefore, increased the risk of harm to the plaintiff.

# How does “foreseeability” fit into liability?

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- Core of a suicide case: whether the suicide was “foreseeable.”
- Foreseeability: **reasonable anticipation** that some harm or injury is likely to result from certain acts or omissions.
- Proper assessment: should reveal the severity of a patient’s risk for suicide, which leads to critical treatment plan determinations.
  
- **Foreseeing a result is not the same as predicting that an event will occur.**



# Role and Importance of Documentation

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- Myth: detailed documentation should be avoided because “lawyers can hang you with it.”
- Good care combined with high quality documentation is the surest way to avoid being a defendant in a malpractice action.
- Documentation is key when reviewing a potential case



# Keeping Out of Court

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- Nothing will stop a malpractice lawyer dead in his or her tracks quicker than a well-documented chart reflecting careful and thoughtful suicide assessments.



If the control panels  
screams danger  
Pay Attention



# What We Often Hear from Clinicians

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- “I did assess for suicide, but I did not document it.”
- “I had good reasons for not hospitalizing; I just did not document them.”
- That dog does not hunt!



# The Rule

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- Does the law embrace the Zero Suicide initiative?  
Enthusiastically!
- A healthcare provider is never allowed to unnecessarily endanger anyone.



# Legal Implications to using the name Zero Suicide

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- Zero Suicide is a focus on error reduction and safety in healthcare; that is your calling.
- Zero Suicide is a framework for systematic, clinical suicide prevention in healthcare systems.



# HIPAA: If misunderstood it can be a proximate cause of a suicide attempt

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“For patients who screen positive for suicide ideation and deny or minimize suicide risk or decline treatment, obtain corroborating information by requesting the patient's permission to contact friends, family, or outpatient treatment providers. If the patient declines consent, HIPAA permits a clinician to make these contacts without the patient's permission when the clinician believes the patient may be a danger to self or others.”

Sentinel Event Alert, The Joint Commission, Issue 56, February 24, 2016

# Hospitalization

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- Hospitalizing patients who talk about suicide compared to less restrictive care – what are potential legal implications?
- Be clear in your risk formulation. Why? Why? Why?

# Professional Judgment

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- When does this defense work?
- Professional judgments can fall below the standard of care.



# Professional Judgment

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Defense likely to fail if:

- The Clinician kept poor records.
- The Clinician has no documented reasoning.
- The Clinician did not “think on the record.”
- The Clinician has no reasonable explanations for his/her failure to intervene and protect the patient.
- The Standard of care v. Standard care (Everyone does it).

## Audience:

Using the chat box please tell us what was most meaningful or poignant to you about this presentation.

# Presenter

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**Lanny Berman, Ph.D., ABPP, PLLC**

Lessons Learned from the Courtroom: An Expert's Perspective

# Suicide Bereaved Attitudes toward Therapists\*

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- Blamed the therapist
- Anger toward the therapist
- Outrage toward the therapist
- Discouraged about the effectiveness of therapy
- Contempt toward the therapist
- Therapist failed

\* **Loved one in therapy at time of death versus no longer in therapy**

(Ward-Ciesielski, Wielgus, & Jones 2015)

# Common Complaints: Failure to...

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- Evaluate need for psychopharmacological intervention or unsuitable pharmacotherapy
- Evaluate suicide risk
  - At intake
  - At management transitions
  - At times of increased environmental stress
- Secure treatment history/records or conduct adequate history
- Conduct mental status examination and/or Diagnose
- Hospitalize, given evident risk

(Bongar, Berman, Litman & Maris 1992)

# Common Complaints: Failure to...

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- Update, Train to, or Follow Policies and Procedures
- Protect Patient from Self-Harm; Implement Safeguards
  - To supervise/observe in hospital
  - To environmentally proof inpatient environment
  - To counsel means restriction in outpatient environment
- Establish (and implement) Formal Treatment Plan
- Treat or Treat Appropriately
- Properly Discharge/Provide Timely Discharge

# Standard of Care

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- What is expected of the ***reasonable and prudent*** clinician.
  - Legal concept
  - Defined by statutes/ethical codes, etc.
  - Opined by experts



**In a courtroom, anything will fly  
if a scientist testifies to it.**



# Reasonable and Prudent Practitioner Behaviors

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- Systematically assess and formulate risk of suicidal behavior
- Protect patient from self-harm
- Develop treatment plan to reduce assessed risk
- Reliably implement treatment plan
- Evaluate progress and revise/modify treatment plan as needed
- Recognize need for continuity of care

# Systematically Assess Risk of Suicidal Behavior

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- In a malpractice action, the *foreseeability* of a patient's suicide will be ***retrospectively*** evaluated by experts based on evidence that was available to the caregiver *before* the act.
- *Was there sufficient evidence to suggest to a reasonable clinician, making a reasonable assessment, that a patient's suicide (or nonfatal attempt) could have been anticipated?*

***Prediction is hard, especially  
when you're talking about the  
future.***

Yogi Berra

# What's Wrong with this Deposition Testimony?

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## **Plaintiff's Attorney:**

Q: And the manner in which you perform your risk assessment is to ask the patient whether or not they have suicide ideation?

## **Defendant Psychiatrist:**

A: Yes

## **Plaintiff's Attorney:**

Q: Is that your first question when performing your risk assessment?

## **Defendant Psychiatrist:**

A: Yes

# Deposition Testimony (2)

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**Plaintiff's Attorney:**

Q: If they say 'No,' does that pretty much end the inquiry?

**Defendant Psychiatrist:**

A: It depends.

**Plaintiff's Attorney:**

Q: On what?

**Defendant Psychiatrist:**

A: Whether I believe what they say, what their mood or affect is.

# Deposition Testimony (3)

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**Plaintiff's Attorney:**

Q: The patient answered in the negative, would that be accurate?

**Defendant Psychiatrist:**

A: Yes

**Plaintiff's Attorney:**

Q: And was there any further inquiry on that?

**Defendant Psychiatrist:**

A: No

# Standard Practice (but not Standard of Care Practice)

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- The Standard Practice in assessing and formulating suicide risk is to begin with questions about the presence of suicide ideation — OK
- If no ideation, current or recent, is expressed, the typical suicide risk assessment ends and risk is typically formulated as either “none” or “low.”
- *This is institutionalized psychotic behavior!*  
(assuming behavioral expressions of acute risk)

# Standard of Care Practice

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- Ask about suicide ideation (SI)
  - If SI is present, peel the onion
- Continue the suicide risk assessment (SRA) even if SI is declined, based on assessment of chronic risk factors (vulnerability to be suicidal) and acute risk factors (associated with near-term risk)
- Suicide risk may still be high and acute even if current SI is denied



# Empirical Data Regarding Those Who Die by Suicide

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The majority of patients who die by suicide actually deny having suicidal thoughts *when last asked prior to their death*

Appleby et al., 1999	Busch et al., 2003	(78%)
Barraclough et al., 1974	<u>Isometsä et al., 1995</u>	(78%)
<u>Chavan et al., 2008</u>	<u>Karch et al., 2011</u>	(NVDRS: 71%)
DeLong & Robins, 1961	Smith et al., 2013	(73% of depressed VA patients)
Hall et al., 1999	Berman (in preparation)	(57%)
<u>Hiemeland, 1996</u>		
<u>McKelvey et al., 1998</u>		

# Reasons for Denial of Suicide Ideation

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- Not thinking of suicide at that moment
- Unclear wording of question
- Poor comprehension of question
- Feared loss of autonomy, loss of functional relationship, loss of employment
- Feared negative judgment/stigmatization
- Belief can't be helped
- Belief = sign of weakness

# Review of 157 Litigated Suicides

(Berman, in Preparation)

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- Suicide Ideation – Last clinical contact before death (**49%** seen within 2 days, **73%** within 7 days of death)
  - **Not asked 16%**
  - **Asked, Denied 57%**
  - Asked, Admitted to Active SI: **12%** (16% of those asked)
  - Asked, Admitted to Passive SI: **14%** (17% of those asked)

# Standard Practice: Active SI Conveys Greater Risk than Passive SI

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- **Standard of Care is to know the research literature**
- The risk of lifetime suicide attempt is similar among those with passive versus active SI (Baca-Garcia et al., 2011)
- “...*the difference between active and passive SI has no clinical utility.*” (Szanto et al., 1996)
- The relative proportion of those who transition from ideation to a plan to an attempt (24.5%) is no greater than those who transition from ideation to an unplanned attempt (26%) (Kessler et al., 1999)

# Of Patient Suicides Who Denied SI When Last Asked

49% seen within 2 days, 73% within 7 days of death

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Variable	Denied SI (N= 89)
Social Isolation/Withdrawal	58%
Angry Irritability	47%
Anxiety/Agitation	78%
Sleep Disturbance	76%
Hx SI/SA	82%
IPP/Job or \$ strain	73%
Hopelessness/Catastrophic thinking	73%
Comorbidity	79%

(Berman, in preparation)

# A Comment on the C-SSRS\*

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- 1-5 rating for suicidal ideation, of increasing severity (from a wish to die to an active thought of killing oneself with plan and intent)
  - Have you wished you were dead or wished you could go to sleep and not wake up?
  - Have you actually had any thoughts of killing yourself?
- “Guttman scaling is not appropriate for the assessment of suicidality.” (Giddens et al., 2014)

\*Columbia Suicide Severity Rating Scale

# A Note on Protective Factors

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- Protective Factors Do Not, (note to self, repeat this), **DO NOT** Protect if there is Acute Risk.
  - Married folks kill themselves
  - Married folks with children kill themselves
  - Priests, Rabbis, and Psychotherapists kill themselves
  - Patients having years of good therapeutic alliance kill themselves
  - Practically everyone has future plans

# Develop Treatment Plan to Reduce Assessed Risk

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- Address modifiable acute risk factors
- Simply medicating the diagnosed disorder is not sufficient
- Implement evidence-based treatments
- Communicate frequently if split treatment
- Involve a Contract for Safety



# Develop Treatment Plan to Reduce Assessed Risk (continued)

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- Maximize continuity of care
  - A simple discharge referral to seek outpatient care for a patient with history of poor compliance is ill-advised
- Attend to motivations/situational contexts that prompted acute suicide risk (Berman, in preparation)
  - Shame/guilt/loss of face/feelings of failure (26%)
  - Feeling trapped (24%)
  - Social isolation/withdrawal (57%)
  - Anticipatory legal/criminal issues (15%)

# The Treatment Plan

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- Protect Patient from Self-Harm
  - Safety Planning (train to)
  - Make efforts toward means restriction
    - Firearms availability and accessibility
    - Available and accessible OTC and prescribed medications
- Actively involve significant others/family in planning and follow-up observation/reporting and to build supportive alliances

# Training: Develop a Competent Workforce

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- Update staff training
  - **AMSR** ([www.sprc.org](http://www.sprc.org)) – knowledge competencies
  - **RRSR** ([www.suicidology.org](http://www.suicidology.org)) – behavioral competencies

# Acknowledgement

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- **Mort Silverman, MD (co-author)**
  - *Suicide Risk Assessment and Risk Formulation*
    - *Part I. Focusing on Suicide Ideation in Assessing Suicide Risk (pp. 420-431)*
    - *Part II. Suicide Risk Formulation and the Determination of Levels of Risk (pp. 432-443)*
      - *Suicide and Life-Threatening Behavior, 44(4), 2014*
  - Berman, A. L. & Silverman, M. M. (in press). Rethinking Suicide Risk and Assessment. In C. Nemeroff, P. Ruiz, & S. H. Koslow (Eds.). *A Concise Guide to Understanding Suicide: Epidemiology, Pathophysiology, and Prevention*. Cambridge University Press.

**Audience:**

**Using the chat box please tell us what was most meaningful or poignant to you about this presentation.**

# Presenter

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**Susan Stefan**  
Zero Suicide and the Law

# Zero Suicide $\neq$ More Restrictions

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- Zero Suicide  $\neq$  More Hospitalizations
- Zero Suicide  $\neq$  More Medications
- Zero Suicide = Systems Approach to Suicide
- Zero Suicide = Embraces Peer Support and Trauma-Informed Care

# State law governs many aspects of treatment for people who are suicidal

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State statutes and case law differ in such critical areas as:

- Medical malpractice
- Civil commitment
- Competence
- Informed consent
- Advance directives/health care proxies



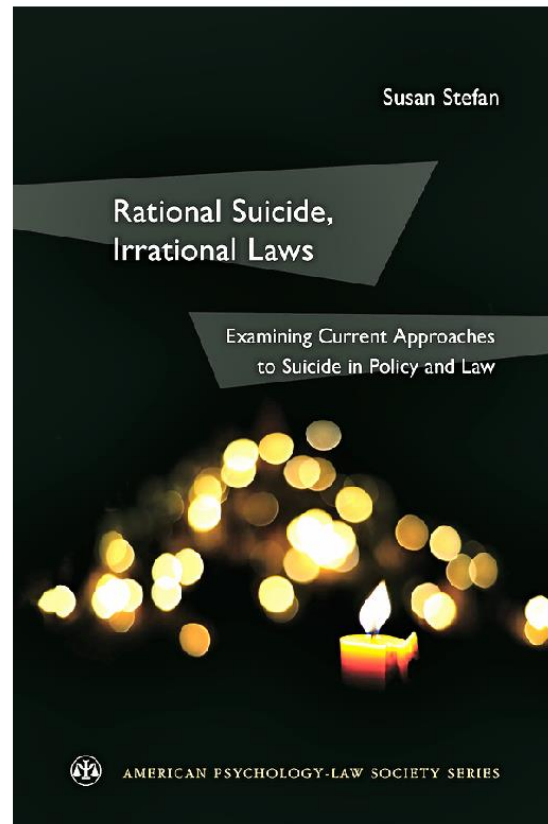
# Malpractice law relating to suicide varies tremendously from state to state

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- Difficult or impossible to establish liability for outpatient suicide (Delaware 2015; Mississippi 2014)
- Outpatient suicide subject to “comparative fault” [*sic!*] (Illinois 1998; Iowa 2011; Kansas 2003)
- Outpatient suicide not subject to any comparative fault (Tennessee 1998)
- Florida deciding this year (*Granicz v. Chirillo*)

# Rational Suicide, Irrational Laws (Oxford University Press 2016)

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# Nevertheless, some generalizations are possible

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- Lawyers rarely take suicide cases
- The decision to sue is not based on bad outcome (the suicide) but because of bad process:
  - Ignoring the obvious
  - Inadequate suicide assessments
  - Risky medication practices
  - Horrible documentation

# Helpful suggestions for:

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- Inpatient facilities/systems
- Inpatient professionals
- Outpatient professionals

# Inpatient facilities/systems

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- Look around!
- Most hospital suicides are hangings
- Between 75-84% of hospital suicides involve environmental hazards
- Pay special attention to patients' rooms and bathrooms
- *Kerker by Kerker v. Horwitz* (N.Y. App. 1990)

# Inpatient facilities/systems (continued)

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## Fifteen minute checks and other fictions

- Death by asphyxiation takes 4-5 minutes
- Between 30-40% of inpatient suicides take place on 15 minute checks
- *Estate of 19 Year Old Doe v. Defendant Treatment Facility*, 2015 Mass. Jury Review Verdicts LEXIS 131 (Oct. 31, 2014)

# Wave of the future? Focus on post-discharge follow-up and support

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- Widely known that risk of suicide is high in weeks/months after discharge
- Importance of tight coordination with new providers
- “Caring Contacts”
- *Kuligoski v. Brattleboro Retreat* (Vermont 2016)

# Inpatient professionals

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- Forget “contracting for safety”
- Do not punish patients for talking about suicide
- Think carefully about med changes
- Involve family when patients agree
- Get past records and read them
- Consult on hard questions



# Prior to discharge

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- Inquire about access to lethal means at home
- Assess and document before discharge:
  - Brief Documentation of Release/Mitigation of Risk (BDR-MOR)
- Listen to and document family concerns
  - Work with pt. to develop specific crisis plan
- Discharge includes referral to CAMS, CBT or other community-based suicide treatment

# Outpatient providers

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- Reconsider hospitalization, especially involuntary hospitalization (Joint Commission 2016)
- Review medication risks and benefits
  - *Grese v. United States of America*
- Learn available crisis alternatives
- The patient is not the problem; the system is the problem

# Wave of the future?

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- Universal screening
- Hospitalization not necessarily the gold standard (no evidence that it helps)
- Safety planning (not “contracts for safety”)
- Direct targeting of suicidality
- More cooperation among systems of care

(Joint Commission 2016)

# Documentation is key

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- Document BOTH the pros and cons of your decision
- Document all patient contact, including telephone and email
- Document using the patient's words
- Document as close to contemporaneously as possible
- Document all contacts pertaining to patient: parents, spouses, insurance
- Document review of medical records

# Needed Systems Changes

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- ICD-10 Coding/Reimbursement Changes
- Liability Reform
- More focus on input from Attempt Survivors
- Peer Suicide Groups (AA/NA Model)
- Stop Rewarding Crisis

## Audience:

Using the chat box please tell us what was most meaningful or poignant to you about this presentation.

## **PLEASE NOTE:**

A list of suggested readings and a compilation of frequently asked questions are included below.

## Zero Suicide Webinar: Legal and Liability Issues in Suicide Care

May 17, 2016

### Suggested Readings

Dawson, D. L., & MacMillan, H. L. (Eds.). (2013). *Relationship management of the borderline patient: from understanding to treatment*. Routledge.

Hall, W. (2013). *Time for a new Understanding of Suicidal Feelings - Mad In America. Mad In America*. Retrieved 16 May 2016, from <http://www.madinamerica.com/2013/04/time-for-a-new-understanding-of-suicidal-feelings/>

Jobes, D. A., & Bowers, M. E. (2015). Treating suicidal risk in a post-healthcare reform era. *Journal of Aggression, Conflict and Peace Research*, 7(3), 167-178.

Jobes, D. A. (2006). *Managing suicidal risk: A collaborative approach*. Guilford Press.

Jobes, D. & Ballard, E. (2011). The Therapist and the Suicidal Patient. In K. Michel & D. Jobes, *Building a Therapeutic Relationship with a Suicidal Patient* (pp. 379-393). Washington, D.C.: American Psychological Association.

Live Through This: [www.livethroughthis.org](http://www.livethroughthis.org)

Maltsberger, J. T. (1994). Calculated risks in the treatment of intractably suicidal patients. *Psychiatry*, 57(3), 199-212.

Paris, J. (2007). *Half in love with death: Managing the chronically suicidal patient*. Routledge.

Paris, J. (2006). Managing suicidality in patients with borderline personality disorder. *Psychiatric Times*, 23(8), 34-34. Available at: <http://www.psychiatrictimes.com/articles/managing-suicidality-patients-borderline-personality-disorder>.

Petrik, M. L., Billera, M., Kaplan, Y., Matarazzo, B., & Wortzel, H. (2015). Balancing Patient Care and Confidentiality: Considerations in Obtaining Collateral Information. *Journal of Psychiatric Practice*®, 21(3), 220-224.

Phillips, M. R. (2010). Rethinking the role of mental illness in suicide. *American Journal of Psychiatry*.

Rudd, M. D., Joiner, T., Brown, G. K., Cukrowicz, K., Jobes, D. A., & Silverman, M. (2009). The realities of risk, the nature of hope, and the role of science: A response to Cook and VandeCreek.

Schmitz, W. M., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., ... & Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and



care: An American Association of Suicidology Task Force report addressing serious gaps in US mental health training. *Suicide and Life-Threatening Behavior*, 42(3), 292-304.

Shneidman, E. S. (1992). Rational suicide and psychiatric disorders. *N Engl J Med*, 326(13), 889-890. Available at: [www.nejm.org/doi/full/10.1056/NEJM199203263261311](http://www.nejm.org/doi/full/10.1056/NEJM199203263261311).

Shea, S. C. (1999). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors*. John Wiley & Sons Inc.

Simpson, S., & Stacy, M. (2004). Avoiding the malpractice snare: Documenting suicide risk assessment. *Journal of Psychiatric Practice*®, 10(3), 185-189.

Stefan, S. (2016). *Rational Suicide, Irrational Laws: Examining Current Approaches to Suicide in Policy and Law*. Oxford University Press.

It is often appropriate to treat individuals outside the hospital who are not acutely dangerous, but who do have some risk factors for harm to self or others. (1-12) This form is a synopsis of key protective and risk factors, mitigation of risk, and clinical decision-making. It is designed to augment individualized documentation and be a reminder of steps to decrease risk. It is not an interview or assessment tool. **Note: Focus is on management of short-term risk. Collaterals, consults, referrals and warnings are particularly important to document.**

### PROTECTIVE FACTORS

#### *Mental Status and Response to Intervention*

1.  Believably reports no overpowering urge to hurt self or others
2.  Not feeling like such a burden to others that death would be a relief to them
3.  Can maintain or regain composure while talking about the acute precipitants
4.  Acknowledges and is motivated to cope with life stressors
5.  Convincingly states reasons for living  responsibility to children  belief system  Looking forward to \_\_\_\_\_  Other: \_\_\_\_\_
6.  Would not want one's dangerous behavior to hurt others
7.  Symptoms known to be risk factors diminish during intervention (e.g. anxiety, agitation, insomnia, despair, rage, psychosis, intoxication, suicidal/homicidal ideation)
10.  Engages constructively with treatment staff
8.  Makes progress resolving the crisis
11.  Shows interest in non-inpatient treatment
9.  Can look back on successfully handling a similar crisis in the past
12.  Presented voluntarily seeking help

#### *Dangerousness*

13.  No thought of attempting harm to self/others during this episode of illness
14.  Aborted attempt to hurt self or others on own/called for help
15.  Suicide attempt or assault did not seriously endanger health
16.  Suicide attempt involved significant availability of rescue
17.  Did not rehearse attempt or make preparation for death
18.  Dangerous action was designed to achieve something other than serious injury or death
19.  Contingent suicidality: Appears to be exaggerating suicidal thoughts for secondary gain <sup>(9)</sup>
20.  **Collateral history corroborates impression of safety OR: Collateral is  unavailable  inessential in this case  unreliable** \_\_\_\_\_
21.  Limited past history of serious harm to self or others

#### *Support Network*

22.  Has a good alliance with outpatient clinician
  23.  Values current job or school
  24.  Has interested and available family and/or friend:  Observed to respond positively to them
- Other: \_\_\_\_\_

### RISK FACTORS

#### *Mental Status and Response to Intervention*

25.  Expresses some thoughts of hurting self or others but with ambivalence
26.  Despair, rage, psychosis, insomnia or emotional turmoil: treated enough for release, but recurrence always possible
27.  Minimizes problems in life and with oneself
28.  Unable to identify or talk about the acute precipitants

#### *Dangerousness <sup>(5)</sup>*

29.  Harm to self or others required medical treatment in ER or hospital
30.  Past history of doing harm to self or others
31.  Family history of or recent exposure to suicide
32.  Recently/Being discharged from psychiatric hospital or observation unit
33.  Problem with substance abuse
34.  Access to weapons
35.  Presence of chronic, disabling medical illness, especially with poor prognosis
36.  CNS trauma, signs, symptoms such as cognitive loss of executive function

#### *Support Network*

37.  Limited availability of interested family, friends or other supports
38.  Shows little or no interest in professional help (Not due to anger at involuntary detention)

Other: \_\_\_\_\_

Addressograph or Name and BHD Number

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION  
BRIEF DOCUMENTATION OF RELEASE  
AND MITIGATION OF RISK

BRIEF DOCUMENTATION OF RELEASE AND MITIGATION OF RISK

MITIGATION OF RISK AND AFTERCARE PLAN

- 39.  **Told to avoid weapons or other means of harm (e.g. medications)**  
 If applicable:  Recommended securing  Secured
  - 40.  **Cautioned individual to avoid alcohol or illicit drugs until crisis is resolved**
  - 41.  **Discussed risk factors and explained the importance of continuing treatment**
  - 42.  **Referred for appropriate, non-hospital level of care:**  partial hospitalization  community-based crisis facility  
 staying with supportive friends or family  intensive outpatient  
 appointment  early appointment with existing provider  outpatient with new provider  
 scheduled follow-up phone call, mobile team visit or other correspondence  
 Other: \_\_\_\_\_
  - 43.  **Discussed exactly what actions to take if symptoms and risk occur.**  
 Safety plan includes:  using personalized crisis plan  call crisis line, warm line or other emergency support  
 return to this facility  go to psychiatric hospital  Other: \_\_\_\_\_
  - 44.  **Consulted with:**  colleague  supervisor  attending  psychiatrist  medical director  
 patient's own treatment professional  patient's future treatment professional  see consultant's note
  - 45.  Treated acute symptoms to the point where they are not high risk factors
  - 46.  Arranged for safe amount of appropriate medication
  - 47.  Helped individual begin to mitigate conflict or crisis in his/her life
  - 48.  Educated significant others and enlisted their understanding and support  Inessential in this case
- Other: \_\_\_\_\_

CLINICAL DECISION-MAKING

- 49.  **Protective factors are more compelling than risk factors**
- 50.  **Patient judged not to be short-term high risk for causing serious harm or death to self or others**
- 51.  Patient collaborated in aftercare planning and prefers non-hospital treatment
- 52.  Patient declines hospitalization, and the risks of coercive care (damaged therapeutic alliance, interference with work and relationships, increased stigma) outweigh the benefits (increased immediate safety, more concentrated evaluation and treatment, more data to support decision to release)
- 53.  Has history of abuse (emotional, physical, sexual) and abuse history is a risk factor, but it is also associated with low-grade self harm <sup>(13)</sup> and a tendency to experience involuntary stays as particularly traumatic. <sup>(12)</sup>
- 54.  Chronic self-destructive potential is not responding to hospitalization. Acceptance of risk is the price of outpatient treatment. <sup>(8, 10)</sup>  Hospitalization might worsen a problem with dependency
- 56.  Contingent suicidality: Patients who threaten suicide if discharged are typically not high risk <sup>(9)</sup>
- 57.  In unguarded moments, patient does not appear to be in as much crisis as he or she reports.  
 Patient self-assessment is out of proportion to observations for \_\_\_\_\_ hours by multiple, trained observers

In particular, \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**References:**

1. Jacobs, D. et al. *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*. pp 52-55. American Psychiatric Publishing Inc., 2003.
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Co-authors of this form (BDR-MOR): Jon S Berlin, MD and Susan Stefan, Esq. Draft 9, October, 2010.

Field trials: please send comments and suggestions to [jberlinmd@gmail.com](mailto:jberlinmd@gmail.com)

**Zero Suicide Webinar: Legal and Liability Issues in Suicide Care**  
**May 17, 2016**  
**Continuing the Discussion: Answers to Frequently Asked Questions**

**How should we manage when the risk is high but not imminent and the client doesn't consent to collateral contact?**

**Skip:** Trying to parse the difference between high and imminent is not possible unless some state has clearly defined the two—unlikely and misses the point of patient safety. I would also try very hard to get consent—it is a treatment issue; use all your skills to get consent and DOCUMENT. Reach out for help from another clinician skilled in suicide assessment & document that too. Answering this is tough without talking about it.

**Susan:** First of all, know your state's law, which may be more protective of confidentiality than HIPAA. HIPAA provides that the law most protective of confidentiality governs the professional's actions. Second, the client's right to confidentiality extends to prohibiting the mental health professional from revealing anything the client has told the mental health professional, but does not prohibit the mental health professional from listening to anything the family or other collaterals may want to tell him or her.

**Lanny:** The clinical prerogative is to first protect the patient. If the risk is imminent, in the clinician's judgment, then confidentiality should be breached. If it is high, but is not formulated as acute (imminent), then confidentiality trumps and interventions should be implemented to reduce that risk. Susan is correct; the clinician can receive information from others about the patient, but cannot give out information about the patient to others without consent.

**How do you navigate breaching confidentiality to consult with collaterals and maintain the therapeutic alliance? When is one more important than the other?**

**Skip:** If performed with care the patient will know you are trying to save them from death. We need everyone on the treatment team if feasible, that is the collaterals are not abusers or simply not able at any level to help—that can happen. As a rule patient safety trumps TA; that is an easy call.

**Susan:** If at all possible, do not “breach” confidentiality, in the sense of breaking confidentiality either without telling the patient or against the patient's wishes. You should discuss, explain and negotiate your desire to consult with collaterals, emphasizing your alliance with the patient, and obtain if possible not only the patient's consent, but his or her understanding. “Consent” in the sense of a signature on a piece of paper may cover you legally, but not therapeutically. Most importantly, be transparent, respectful and honest with your patient in all your interactions, even those to which the patient objects.

As to “when is one more important than the other” remember that a therapeutic relationship is dynamic. Your actions and omissions can have a major impact on an individual's emotional framework and his or her behavior. It's better to consult with collaterals to obtain information in order to be of the greatest assistance to the patient, but not at the cost of the patient's feeling betrayed and ganged up against (again).

**Lanny:** Remember, a great deal of what clinician's must do requires clinical judgment. My take on this is somewhat different than Susan's [see judgements can lead to different actions and that's fine, if rationales for these judgments are documented (and make sense)]. If in your judgment, it is critically important for collaterals to be informed, to be involved in their loved one's care, to share their information/observations, etc., and, in the context of high and acute risk, then confidentiality may and probably should be breached. Yes, the risk is a damaged therapeutic alliance, but the reward may be a saved life and a consequent opportunity to repair that alliance. The paraphrased adage is: *Better to protect the patient and act to preserve life than to risk a death in the service of confidentiality.*

**Many clinicians use the framework of "imminence" (likelihood of doing something self-destructive or lethal in the next 24-48 hours). How do you feel about this legally? What is the time frame—at each point in time—in terms of foreseeability?**

**Skip:** Not good—how about 49 hours and so on? At some point the duration becomes unworkable; forecasting is tough. By the way no one is that good—really, 24-48 hours? It is a notion not based in reason.

**Susan:** Many (but not all) states have definitions of imminence in their involuntary commitment statutes and case law. I discuss many of these definitions and case law in Chapter 2 of my book. What I would advise as a practical matter is to concentrate not on what may happen in 24-48 hours, but what specifically *has* happened in the last 24-48 hours—in other words, what are the specific, tangible acts of conduct or statements that have driven you to start thinking about what might happen in the next 24-48 hours?

**Lanny:** It is the courts who have framed the term "imminent," not clinicians. We simply cannot predict a patient's behavior in the next hours to days. No less, no one has reasonably defined the number of hours implied by the term. Our task is to assess risk and if that risk assessment is that "in my judgment this patient is more likely than not in the near-term to do something to harm or kill him/herself, then I must act accordingly to protect the patient from that assessed risk." A must read on this topic: Simon, R. I. (2006). Imminent suicide: The illusion of short-term prediction. *Suicide and Life-Threatening Behavior*, 36(3), 296-301.

**E.R.'s are becoming the front line for people in a suicidal crisis. E.R. When choosing not to medicate patients who are not acutely suicidal, are E.R. physicians exposing themselves to liability?**

**Skip:** If the ED physician has a qualified and competent mental health consult addressing these issues carefully and that consult is carefully documented liability is severely attenuated. Make sure the mental health consultant specifically addresses your concerns. Follow the SPRC ED guidelines and cite them in your charting. Again think on the record. Make sure collaterals know if patient is being discharged and alert them to means restriction. All of this is addressed in guidelines. Get them and use them. We talking about weapons do not forget the car as a hiding place and every hiding place within the car. Think like a police officer looking for guns and drugs.

**Susan:** I wrote a book called *Emergency Department Treatment of the Psychiatric Patient: Policy Issues and Legal Requirements* (Oxford University Press 2006) that looks comprehensively at malpractice cases and concludes ER physicians are more at risk prescribing new meds to patients whose history they are not familiar with than by not prescribing new meds. The other real problem is when people need access to their *current* meds and can't get them while they wait at the ER. Optimally, the ER doc can confirm those meds with the patient's treating mental health professional or pharmacist, but sometimes this is difficult to navigate. Hopefully electronic records will make these issues simpler.

### **What does it look like having a thorough systematic suicide assessment?**

**Skip:** Shawn Shea and James Knoll, M.D. are good starting places. And of course Lanny Berman. AAS has excellent courses too. Check the AAS website.

**Susan:** It looks like a conversation between a distressed person and a person who cares about that person's individual distress. It does NOT look like a person with a clipboard reading questions. Dr. Jon Berlin has written some great articles about assessments in the ED, see especially chapters in the book he edited with Dr. Rachel Glick called *Emergency Psychiatry*.

**Lanny:** See the articles on suicide risk assessment and suicide risk formulation I referenced at the end of in my webinar presentation, written by Mort Silverman and myself and published in *Suicide and Life-Threatening Behavior* in 2014.

### **How do you assess for suicide if the individual is denying SI, despite having red flags?**

**Skip:** See answer above. It is imperative to know how to interview folks who don't want to chat about drugs, sex, suicide, homicide. Shea is the best in the world on interviewing. Get his books, go to his courses—always presented at AAS conventions.

**Susan:** SI is not a +/-, yes/no kind of condition. It's a dynamic spectrum, and your very interaction with an individual can make him or her suicidal, or mitigate, diminish and comfort a person who wants to die. Is the denial of SI the passive resignation of a person too exhausted to organize a suicide attempt or is the denial of SI an affirmative exclamation of the joy of living or is the denial of SI rooted in loyalty to family or faith? You assess a person by being genuinely curious about who they are and what life is like for them.

**Lanny:** As I described in my presentation and as further delineated in the articles just mentioned above, the denial of SI does not equate to the absence of suicide risk. If there are a number of other red flags sufficient to make the clinician wonder (in the chart) why this patient is not thinking of suicide given what is being assessed (red flags), then the patient may still be assessed as acutely at risk for suicide. There are lots of reasons why a patient may deny thinking of suicide, but still be at acute risk. The clinician's task, most difficult as it is, is to get inside his/her patient to see and experience their life/world as they do (that is true empathy) and recognize that if life is deemed anguished and intolerable, what one says at this moment (about SI) may not be what one will be thinking in the next moment. The treatment plan must be directed to reduce the acute risk.

**Can you please clarify the difference between denying ideation and not having ideation and resulting deaths.**

**Lanny:** I suspect this distinction is not possible prospectively. Again, if a patient denies SI and does not otherwise appear to be in a potentially suicidal crisis, then it is reasonable to assess the patient as at lower risk. However, if the patient describes significant vulnerability (diathesis) and ongoing intolerable stress and is “leaking” signs of duress despair, anguish, catastrophic thinking, hopelessness, irritability, insomnia..., then suicide becomes a potential act.

**Can you provide any references from the research to back your statement that protective factors do not reduce the imminent risk of self-harm?**

**Skip:** It is important to remember that as intent and symptom severity escalate, protective facts tend to diminish. M.D. Rudd, *The Assessment and Management of Suicidality*, 2006, p.45: “No protective factor is absolute. The acuteness and severity of mental illness can nullify protective factors.” See also: R. Simon, M.D. *Preventing Patient Suicide: Clinical Assessment and Management*, (2011), p.54.

**Lanny:** Not directly, but psychological autopsy studies, no less legal cases, are replete with anecdotal evidence that every listed “protective” factor can be found among suicides. So, the data to support the statement is retrospective, based on case series of suicides, and not from an RCT. That said, it is also “common-sensical” – if a patient is overwhelmed by acute risk factors that constrict the patient’s ability to think rationally, to apperceive their external world as supportive and dynamic such that change for the better can be assumed with time or change of circumstance, etc., then protective factors will potentially be trumped by a painful and intolerable state.

**I’ve always heard that contracting for safety is no longer recommended and safety plans should be the standard instead. Can you please expand upon your recommendation to include contracting for safety?**

**Lanny:** As I mentioned in the webinar’s chat, my use of the word “contract” clearly – and unintentionally -- confused participants. “No suicide contracts” or “No harm contracts” are decidedly ineffective. Patients at high and acute risk cannot reasonably assure the clinician that they will not act on suicidal thoughts when in the midst of a suicidal crisis. These are still used, mostly in inpatient settings, and may help a clinician assess the patient’s controls, but they assuredly do not prevent suicides. The jury is still out on the evidence for Safety Planning, but safety plans are the current zeitgeist and data to demonstrate their effectiveness is being collected as I write. These should be implemented as part of the treatment plan and should be documented indicating that the patient understood the steps outlined in the plan. I prefer that the patient indicate this understanding by having a copy of the safety plan – with the patient’s signature attesting to understanding the plan and intent to act on the outlined steps therein – hence my use of the phrase “safety contract.”

**Where does a/the "No Harm Contract" fall, this point, with regard to current Standard of Care?**



**Susan:** I think it's a bunch of baloney. Good luck explaining to the jury how you plan to enforce this when the person is dead.

**Lanny:** Here, here!

**Should a safety plan be made up when the person is in crisis or should a safety contact plan be used? (Safety contact plan: agreeing to call in each night by a certain time otherwise a wellness check will be asked of from the police.)**

**Susan:** Ideally, some kind of safety plan is devised at the beginning of a treatment relationship, even if no crisis exists. You don't want to be flying by the seat of your pants when a crisis does happen. You are probably going to have to talk about limits of confidentiality and what to do if something comes up between appointments. Talking specifically about coping strategies and support networks in this context makes sense (it also may be a time to bring up whether the person is comfortable talking to people in the person's support network).

**Lanny:** I can't think of why a safety plan would be developed and agreed to if the clinician did not think the patient's ability to maintain their safety is in question. Yes, these should be developed before a crisis arises, but only in the context where that is judged to be expected.

**What is the BDR-MOR? (Note: included at the end of webinar slides)**

**Susan:** This is a very brief document created by Dr. Jon Berlin and myself to help ER people who would otherwise be inclined to hospitalize an individual because of risk aversion to consider whether they can/should be discharged and how to document that discharge. I think the document is transferable to other settings. It should not be used as a checklist with the patient, but rather to orient the ER or other staff to the important issues to be considered in deciding and documenting a discharge or admission.

**Anything to help the 50% of suicide deceased who are NOT in healthcare?**

**Susan:** YES YES YES!!! Understand, publicize and educate that suicide is a public health problem, not some niche for mental health professionals that the rest of us don't have the expertise to deal with—frankly, the mental health profession cannot bear the burden of this issue and should not, because then we lose sight of issues like availability of guns and Congress passing laws prohibiting the CDC from collecting gun-related data; we lose sight of the very beginnings of the suicide trajectory in childhood trauma, violence, and economic stresses; we lose our understanding of the nature of community and collective responsibility for lonely old people and bullied children. You can take your pick of any of a number of projects: work on bullying in your local schools; work with battered women and victims of domestic violence; vote for and work for laws regulating access to guns; try to figure out who the seniors are in your community living by themselves who need help and maybe go visit them.

AND, maybe, just maybe, work on making the mental health system a little more inviting so that people can talk about wanting to die without being rightly scared of being hospitalized; pass liability reform for mental health professionals so they can take the risks that accompany helping people

who want to die, promote and fund peer crisis groups and respite care. I could go on, but I believe you get the picture.

## Legal and Liability Issues in Suicide Care\_5

Speakers: Julie Goldstein Grumet, Skip Simpson, Lanny Berman  
& Susan Stefan

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>> JULIE GOLDSTEIN GRUMET: Zero Suicide is a framework for providing systematic, clinical suicide prevention and care. It is a set of seven dimensions. A comprehensive zero suicide approach could be adopted by an outpatient behavioral healthcare facility, an inpatient hospital or a primary care clinic that has behavioral health providers on staff. We've recently gotten requests even to think about zero suicide in substance abuse settings, in correctional facilities, how people might be able to embed these dimensions in their particular domain.

Zero suicide is about how the system addresses suicide care as an ongoing patient safety and performance improvement initiative. So using this box to describe the components, the outer box really highlights the pieces that need to be in place. There must be leadership commitment to safety, accountability and transparency.

And there must be a workforce. The entire workforce beyond just the clinical team that is competent, confident and caring and prepared to identify people at risk for suicide even if that's not part of their core components of their job but they should be comfortable asking people who come into their healthcare system if they seem to be having thoughts of suicide or if they can link them to somebody.

The inside box are the components of care, which include systematically identifying and assessing for suicide risk. We must provide care that directly targets and treats the suicide using effective evidence-based treatments.

We have to provide contact engagement and support especially after acute care transitions. All of this needs to be wrapped in a suicide care management plan, a plan that establishes what the

routine is for people identified as at-risk for suicide that is consistent across our organization and that all our providers have been trained to do.

Finally the system needs to consider how to collect, analyze and review data and then to use that data to make changes to their practices, their policies or their trainings.

This is our website. This is the landing page. Within this website are a lot of materials, both descriptions of what is zero suicide. In the green box on the right hand side is what we call our tool kit which is step-by-step instructions for each of the seven dimensions that I very quickly went through on the previous slide. There are instructions and tools for how to get started, resources and additional readings.

This is where all of our webinars are archived that might help highlight some of the points in a deeper manner, including speakers that have implemented zero suicide and are sharing their best practices and strategies.

We recommend that you put a team together to walk through the website including an organizational self-study that you can download to really reflect on your organization's best practices and what are you doing. Where could you improve? How might you want to begin and where are the gaps in your service delivery?

This is our contact information. You're free to contact us for training or technical assistance if you desire.

And now I'm going to turn over to today's webinar. By the end of this webinar we want you to identify misconceptions related to provider liability in litigation involving patient suicide. We hope that you'll be able to describe suicide care practices that are of particular importance in liability cases. And we're looking to explain system or organizational level improvements to suicide care that can enhance your organization's abilities to deliver quality care and minimize liability concerns.

Our three presenters are excellent. They're nationally recognized. They're incredibly knowledgeable and generally I know that you'll learn a lot from today's webinar which explains the high number of people signing up for it. As we said, it'll be archived for you to share or to go back and refer to.

So we're very fortunate to have Skip Simpson, Lanny Berman and Susan Stefan with us today. At the end of each of their

presentation, we'll invite you to use the chat box that we opened up with to tell us something that was really meaningful or poignant or some kind of learning principle that stood out to you about the presentation so we can have an opportunity maybe to highlight things that you're learning throughout their presentations and allow others to reflect on that.

Throughout the presentation the Q&A box on the left hand side of your individual screens will remain open and you can submit questions there. At the end of the presentation of all three presenters we will have some time for Q&A so you can write your questions throughout and we will have a chance to go through as many of the questions as we can at the end of today's presentation.

So our first presenter is Skip Simpson. Skip is an adjunct Associate Professor at the University of Texas Health Science Center at San Antonio. He is nationally recognized for his expertise in suicide and repressed memory cases. He lectures nationally on avoiding the psychiatric malpractice snare. He is a current Board of Director and member of AAS on the faculty for the QPR Institute. He reviews 70 to 80 suicide cases annually for litigation and he usually accepts about six for prosecution.

He's been an excellent partner in the Zero Suicide Initiative. Any of you who are active on the AAS list serve or the zero suicide list serve will see Skip and really all three of our presenters often engage with the content that you're writing in about the list serve, answering your questions and generally all three making themselves available. So I know this conversation can continue after today throughout all of those additional resources.

So without further ado, Skip.

>> SKIP SIMPSON: Thank you, Julie. I appreciate it. I am very happy to be here to talk to you about zero suicide. The first slide there says fear not, just do it. I'm not trying to be flippant with that kind of remark but what I want you to do if I'm successful in my presentation is that you're not going to fear zero suicide that you're going to embrace it.

This is to me is much like what I used to do when I was with the Air Force and the DA's Office in Dallas and as a federal prosecutor in teaching law enforcement people how to engage on the street and how to conduct searches and to do it right. I realize that when you guys are in the trenches just like the

police are that things move fast and you've got to think quickly and be on your game.

What my goal is to try to help you to help your patients in getting the job done. In my view, zero suicide is like a northern star. It's constant and it's dependable. It's a dependable guide to help you think about what it is you're doing all the time. So every time I take a call, I'm thinking of zero suicide and that is something that you should probably say to yourself 70 times a day; zero suicide. Every time you engage with a patient it's about zero suicide.

I'm going to be addressing issues about confidentiality and HIPAA and customary care and least restrictive environment. Those are the kinds of things that can be distractors to you and I'm going to tell you why.

So when we're thinking of liability, what we're thinking of here, I see what's on the screen and I don't want to get caught up in legalese and I want to help you think about what it means to have a duty and what it means to have breach of duty and that which proximately cause damages.

So if you think of duty, it's like being on the street and running through a red light. You have a duty to stop at the red light. That's your duty. If you run the red light then that's a breach of duty. If you run into someone and you cause damages then that's the proximate cause element. So it's duty, breach of duty with proximate cause damages.

And then it's up to someone like me, a plaintiff, to prove that duty and breach elements by showing that the defendant's act or omission fell below the standard of care and therefore increased the risk of harm to the plaintiff. So the kinds of breaches that I think about are not having a patient on the right observation level in a hospital, not properly assessing someone for suicide and those kinds of things. Those are duties that we have and when you breach those then that can cause harm to the plaintiff.

So how does foreseeability fit into liability? The core of a suicide case is whether the suicide was foreseeable. I like to think that is like using a flashlight and you're going into a home or a big mansion and you're looking around for danger. So you're using that flashlight to go into the corners, shine into the corners, show into every nook and cranny that you can looking for danger.

So it's foreseeability. It's the reasonable anticipation that some harm or injury is likely to result from certain acts or omissions. Foreseeability is not predictability. It's foreseeability. It's anticipating something might happen that's bad. So a proper assessment should reveal the severity of a patient's risk for suicide, which leads to the proper treatment plan determinations. Again, and this is a big issue, foreseeing a result is not the same as predicting that an event will occur.

So when you see this slide and you're seeing a banana peel, we know that the guy that's getting ready to step on the banana peel may or may not have something bad happen to him. He may fall on his backside and hurt himself. He may paralyze himself. He may do any number of things but we don't know that will happen. We can foresee that will happen but we can't predict that will happen so that's the distinction between prediction and foreseeability.

What we want to do in mental health is remove all the banana peels that we can possibly do in the health industry. Q15, every 15 minute watch. It's a dangerous observation level so we want to remove that banana peel. What we want instead is line of sight.

Another banana peel is inadequate assessment. If we're having an inadequate assessment and not getting into a listing, a suicidal ideation of our patient in front of us, if we're not doing that properly that's a banana peel where someone can fall and hurt themselves.

Listening to the suicidal patient, that is very important. It's not just put everybody into the hospital. Sometimes people do that to think that's the safest way to go for themselves to avoid liability but that's not the issue. The issue always is the patient that's in front of you so you have to listen to the suicidal patient and make judgments from what you're hearing.

So talking about documentation. This is another issue, a big one. There's a myth that detailed documentation should be avoided because lawyers can use that to hang you with. That's just not the case. Good care combined with high quality documentation is the surest way to avoid being a defendant in a malpractice action.

So those words just come off my mouth real easily but what you have to think about is really documenting your case. There's a number of good ways to document a case. I think that *The*

*Practical Art of Suicide Assessment* by Shawn Christopher Shea, Appendix A tells you how to document a case. I'd recommend that.

So this is obvious to me at least. Nothing will stop a malpractice lawyer dead in his or her tracks quicker than a well-documented chart reflecting careful and thoughtful suicide assessments.

However, just like in an airplane if the control panels are screaming danger, you have to pay attention to what those lights are. You can't just document that someone has suicide risk and in all the indications on the control panel are that the person is at high risk and then put someone on an every four hour observation level for example because that would never work so that's something that we would be paying close attention to.

What we often hear from clinicians, or I do in depositions that I take, is I did assess for the suicide but I didn't document it. Well if you don't document it then I'm already thinking that if you're not paying attention to documentation something that we've been practicing and preaching for at least 20 years, that tells me something else probably wasn't done.

You might say I had good reasons for not hospitalizing. I just did not document them. I want to know what your reasons are for not hospitalizing a patient that is at high risk. There are good reasons from time to time to do that, probably more often than not because hospitals in many cases aren't real safe places. We don't know exactly how many people are dying from suicide in inpatient facilities because we don't have a good count on that. But we know that the number is pretty high.

So these two reasons I did document, I mean I did assess but I didn't document it, those kinds of comments in Texas, which is where I'm coming from is that we have a phrase that dog does not hunt. It just doesn't work.

So the rule. Does the law embrace Zero Suicide Initiative? The answer to that is it does so enthusiastically. The healthcare provider is never allowed to unnecessarily endanger anyone. What do I mean by that?

Getting back to the inpatient suicide scenario, if you have a chance to put someone on Q15, every 15 minute watch, every 30 minute watch, and you do that instead of putting on someone on line of sight then that's an unnecessary danger to patients. We're never allowed to do that, unnecessarily endanger anyone.



If you had a chance to assess someone for suicide and you didn't do a thorough job of that then you're never allowed to unnecessarily endanger anyone and if you don't do a good suicide assessment that's what is happening. I've got to keep coming back to the fact I'm here to help. You keep focused on what it is that you should be focused on. I know most people that are on these webinars are already doing that.

So what are the legal implications to using the name zero suicide? The answer to that is none. Zero suicide is a focus on error reduction and safety in healthcare. That's our calling. That's your calling. That is what you should have been doing long before the name zero suicide ever came out but again zero suicide is like that northern star that we can guide on. It's a framework for systematic, clinical suicide prevention in healthcare systems whether it be in jails, whether it be in prisons, whether it be in the military, no matter where it is it's a way to think about how to prevent suicide.

HIPAA. Everyone worries about HIPAA. I think HIPAA is one of the biggest killers we have in the United States as it relates to suicide. If misunderstood, it can be a proximate cause for a suicide attempt. What I've set out here is language that comes right straight from the Sentinel alert from the Joint Commission, Issue 56.

Essentially what it says, if danger is an issue and you want to talk to collaterals for example about let's say you have a patient that comes in and he has a bunch of risk factors and he says or she says you know I have all these risk factors but I haven't even thought about suicide. Suicide is not on my mind.

Well you know better so that's the time to pick up the phone and start talking to collaterals, talking to prior care providers and getting a better sense of who is it that's sitting in front of you. What more information can I get because I know I've got to get it? You cannot have all these risk factors for a suicide and have never thought about suicide.

So one of the questions you would ask is when is the last time you thought about suicide? Well I just never have thought about suicide. That's when you really have to get into what you know about assessing for suicide and again I recommend Shawn Shea's book on *The Practical Art of Suicide Assessment*. By the way, I'm not getting any money from Shawn Shea. I'm just saying I've read the book and it's a good guide.

How about hospitalization. Hospitalizing patients who talk about suicide compared to less restrictive care. What are the potential legal implications? Again why didn't you put someone in the hospital? I just want to know, the lawyers want to know, we want to know why, why, why so be really clear in your risk formulation. You guys have good training. You know what to do but get it into the document. Have competent care.

Now one of the things that folks think about is professional judgment. You say well that was my professional judgment and that's the reason why I ran that red light. I thought it was a good idea to just go ahead and run the red light. Well again that dog doesn't hunt so can professional judgment fall below the standard of care? It can and it does. I see it all the time so you just can't use that was my professional judgment as an excuse.

It's just like with every 15 minute watch again. You might say well everyone does it so that's why I did it. Well everyone does it after the age of six years old this is not a very convincing excuse to use anything other than line of sight.

Another thing I hear, an excuse that I hear is Q15 is okay because no one has ever been hurt before. That is luck. That's not an excuse. When we're talking about professional judgment, can it go below the standard of care? Yes it can, so if you're thinking about using that as an excuse that's not going to work.

So the defense likely will fail. That is the professional judgment defense if the clinician has kept poor records so keep good records. The defense will fail if the clinician has no documented reasoning. We want to see what you were thinking. Write it out. Tell us. Think on the record. That is something that is going to help you more than anything else.

So when I see a file as I'm reviewing the records that I receive from folks wanting me to see whether they have a case or not then what I'm trying to see is did this clinician really have his or her head in the game? Is her heart here? Is there someone that really wants to save their client?

So the clinician -- another way it will fail if the clinician has no reasonable explanation for his or her failure to intervene and protect the patient. We need to see that. And really what we need to -- let me tell you the difference between the standard of care and standard care.

The standard of care in Texas it's 70 miles an hour on our freeways. That's the standard of care. Standard of care in Texas on the freeways is 85-90 miles an hour. Everyone is doing it so everyone doing it doesn't work when the policeman stops you and says you know you're getting ready to get this ticket for going 90 miles an hour and you say well wait a minute officer. Everyone is doing it. That doesn't work. That's standard care.

Just because everyone does it doesn't make it right and I hear that all the time particularly in the cases I'm doing in hospitals is that everyone uses Q15. First of all, I don't know that's accurate but if it is accurate it's certainly not safe. It's not the standard of care. The standard of care also means that you're doing a systematic suicide assessment so you are getting all the information you need to know and from that follows how you're going to protect your patient.

This stuff, all that I've been talking about today, I take very seriously. I know you take very seriously and I hope that some of this information you can use in keeping your patient safe and also in relaxing and not letting the law get in your way. It can become like a net over you. You're more worried about getting sued than you are about taking care of your patient.

So what you have to be doing is thinking about your patient, not thinking about yourself and whether you're going to get sued or not. Be competent and documenting your record and if you do all that then I doubt that we'll ever be meeting across the deposition table. Thank you.

>> JULIE GOLDSTEIN GRUMET: Thank you, Skip. So many great points to consider and some real excellent examples.

So I'm hoping just for a moment or so those of you participating in today's webinar maybe type something into the chat box. What stood out for you? What's something new that you learned or you are going to go back and think really thoughtfully about after today's presentation, meaningful poignant to you? Let's take just one minute to see what came up for you during that presentation.

I can see that multiple people are typing. There is no organizational risk in using the term zero suicide. Certainly this is a question that comes up repeatedly. It sounds like somebody is going to consider restructuring their documentation and that the law is on your side if you document properly.

Somebody commented I like the idea of thinking on the record. I think we've definitely been taught that your documentation needs to reflect why you did the actions that you chose to do, not just some sort of vague decision making process but what was your thought behind it.

It looks like for a lot of people really the documentation resonates with people. We'll give people about ten more seconds to kind of type some comments and take a look. It looks like a couple of people are oh we already use Dr. Shea's case approach. I don't know, somebody at the end said they ordered the book. Maybe they did that on Amazon while the presentation was going on. I don't know if Dr. Shea is on today's presentation but we'll certainly have to let him know that he really has a meaningful resource for us.

All right well thank you. I know I see a couple questions that came up and we'll get to some Q&A at the end as well. We'll have an opportunity to take some of your questions at the end.

We're going to move on to our next speaker, Dr. Lanny Berman. He is an adjunct Professor in the Department of Psychiatry and Behavioral Sciences at the Johns Hopkins University School of Medicine. Concurrently he maintains a private practice of forensic and psychological consultation. Between 1995 and 2014, he served as the executive director of the American Association of Suicidology. He's a past president of AAS and of the International Association for Suicide Prevention. Lanny.

>> LANNY BERMAN: Thanks, Julie. Good afternoon or morning or I guess evening to some of those of you online. I'm thrilled to know that so many people joined the webinar and I hope that what we are giving you today will be of use.

The latest data from the national violence death reporting system from 2014 informs us that somewhere between a quarter and a third of all those who died by suicide here in the United States were in mental health treatment at the time of their death. That means roughly 12,000 people are suicidal desendants each year are in our care.

There are two lessons from this. One is tragically suicides happen in healthcare systems and during mental healthcare by individual providers and in that sense suicide has been described as an occupational hazard. Therapists are expected to help patients, to improve their lives, to manage or ameliorate their problems and above all to protect them from self-harm.

It's very important to note that zero suicide has a focus on reducing errors in healthcare and increasing safety but when it's a suicide it's an implicit failure. Family members, spouses, parents, children will be bereaved understandably and quite likely angry and angry at the therapist.

When you see on the screen is a slide from a study published just a year or so ago which sampled a large number of survivors of loss, loss survivors relatively to the suicide of their loved ones. You can see the kinds of anguished hurt and angry feelings that were found to result from the death.

But particularly the notion that the therapist who was treating their loved one has that anger projected towards them and that is that there's going to be blame. And if there is blame there may well be someone like Skip or Susan who is going to come into the story because that loved one is going to go seek an attorney's advice.

An attorney will get your chart and review that chart and as Skip said if from their perspective if there is some merit in the possibility of logging the suit they'll seek input from an expert and they may file a malpractice case on the basis of both their own and their expert's feedback with regard to the possibility that there is either an omission in the standard of care or perhaps even worse a commission.

If indeed a suit is filed, this and the next slide that I'm going to show you represent the common kinds of complaints that are made. In a typical malpractice action, there may be questions about the issue of whether the medication was considered, whether the appropriate medication was given to the patient depending on the patient's diagnosis.

Most profoundly with a suicide risk was continually evaluated, not just initially, hopefully at least initially, but at every opportunity whether management transitions or changes in the environmental surround of the patient in terms of increased stress or events that might prompt some kind of more crisis oriented response.

There will be questions about whether prior treatment history and records were consulted and sought. Were their mental status evaluations and/or diagnosis was given to a patient. And obviously if a patient was considered to be at significant risk whether hospitalization was considered. As Skip said, hospitalization is not necessarily a given even when there is

moderate to high suicide risk but clearly a suitable option has to be built into the treatment plan if hospitalization is not seen as the appropriate treatment to provide, a treatment setting.

In institutional settings and mental health centers, policies and procedures are in existence and they need to be followed and they need to be trained to. They sure not ought to be 15 or 20 years old because our field is growing and expanding and we're learning day-by-day. In that developmental history of suicidology and suicide prevention policies and procedures should follow.

Above all, clinician's responsibility is to protect the patient from self-harm and make sure that there are safeguards in the hospital or in any kind of residential center so that one cannot for example hang oneself which is the most commonly used method to suicide in institutional settings.

So environmentally proofing the inpatient environment is important to make sure particularly at discharge from an inpatient setting or in outpatient care to counsel patients and their families about firearms in the home in particular, safe storage and if necessary even removing the firearm from ready access.

Good assessment should be followed by a formal treatment plan. That treatment plan should be implemented appropriately and obviously in an institutional setting discharge should consider continuity of care issues and educating the family etc. on being sort of allies to the clinician and clinical staff should things change.

What is expected of a clinician? The clinician is simply expected by the law to be reasonable and prudent. What in the world does reasonable and prudent mean? Typically that concept is defined by ethical statutes, by state statutes, by prior cases but most importantly is it comes from the opinions of experts.

One reason why you simply don't want to get into this play, you don't want to be an actor in this play is you never know what an expert is going to say. There's going to be an expert on the plaintiff side. There's going to be an expert on the defense side and they probably and most assuredly are not going to agree on what the standard of care is.

I was involved in one case many years ago where a nationally known expert was testifying for the plaintiff and arguing that the clinician in that case as all clinicians according to this expert needed to be available and accessible at all times to a suicidal patient. And therefore if the clinician did not carry a beeper, according to this expert, he was practicing below the standard of care. That's not true. I've surely had arguments against that but I want you to understand you never know what experts are going to say.

A reasonable and prudent practitioner has several primary functions. I'm trying to, on this slide, give you sort of the basics. I want to specifically talk mostly to the first bullet on this slide and that is the importance of systematically assessing and formulating suicide risk. What follows from that is obviously protecting the patient from self-harm if it's assessed to be present or the potential is assessed to be present.

Developing that treatment plan, which is designed to modify risk factors, that are indeed modifiable. To reliably implement that treatment plan. To make sure that we evaluate and modify how we're doing and if we're not doing well usually our patients let us know. Then we need to modify what we're doing and/or transfer the patient to a different form of care and a different clinical involvement.

And always to recognize the need for continuity of care particularly at discharge from inpatient units. Now as Skip said, the primary issue here is not prediction. It's foreseeability and the responsibility of a clinician is to think in effect retrospectively as one is treating someone prospectively. That is am I paying attention to everything that this patient is telling me, everything I know about this patient, everything that I can potentially anticipate that could trigger suicidal behavior and acting in accordance with that to reduce the risk of that behavior.

An expert in a malpractice action obviously will be looking at your chart, your documentation retrospectively but that expert is going to be putting himself or herself in the position to ask should this clinician at the time of treating this patient have known or have reasonably been able to anticipate some negative outcome.

We're not talking about prediction, let me be very clear. Weather forecasters are terrible at predicting whether it's

going to be raining 48 hours out. Their predictions are almost less than 50% correct even 24 hours out when they're talking about the chance of precipitation.

Clinicians don't have anything near the quality and rigor of science behind them when they're addressing suicide risk. We're talking about foreseeability, not prediction.

I'm going to give you a very quick example of a deposition testimony from a psychiatrist who sued in a malpractice action to try to illustrate Skip's point about the difference between standard versus standard of care.

This is the attorney's question. And the manner in which you perform your risk assessment is to ask the patient whether or not they have suicide ideation. The psychiatrist answers yes. Is that your first question when performing a risk assessment? Yes. If they say no, does that pretty much end the inquiry? Well it depends. On what? Whether I believe what they say. What their mood or affect is.

In this case, the patient answered in the negative. Would that be accurate? Yes. Was there any further inquiry on that? No. Well my question is rhetorical. What's wrong with this is the defending psychiatrist is relying heavily on the patient's admission or in this case denial of suicide ideation as the key question in doing a suicide risk assessment. This is typical across most clinicians dealing with potentially at risk patients.

The key question is are you thinking about suicide? If the patient says no, I'm not thinking about suicide typically the assessment is formulated as low or even none and that ends the assessment. You'll see my editorial comment there. This is institutionalized psychotic behavior when there are other symptoms and behaviors that illustrate that the patient may well have acute risk.

There are lots of reasons why a patient may deny thinking about suicide. We surely, I don't want to be misunderstood here, we surely have to ask about the presence of suicide ideation. And if the patient answers affirmatively yes, I've been thinking about suicide, we need to figure did we peel the onion and that is to understand the frequency of that ideation, the kind of ideation, the duration of the ideation, how well it's been controlled, lots of questions follow.



But irrespective of the answer to that question, we have to continue doing a suicide risk assessment even if ideation is denied. Suicide risk may still be high and acute or what attorneys like to call imminent even if current ideation is denied.

In fact, there are lots of studies in the literature. Most clinicians unfortunately don't read this literature but there are lots of studies in which patients were reporting no suicide ideation within days of dying by suicide.

If you look at the right hand side of that slide, some of the proportions of patients again assessed for suicide risk by asking are you thinking about suicide who denied thinking about suicide prior to dying within days; 78%, 78%, 71% and 73%. A study I'm going to share a little bit with you in a minute 57%.

The majority of people who die by suicide may well deny thinking about suicide at the time they're asked. Here are some of the reasons they may deny it. Number one, they may not be thinking it at the moment. That's not to say they won't be thinking it an hour later. It may have a lot to do with how we ask the question. Are you thinking about suicide? Are you thinking about killing yourself? Are you thinking about death? Have you been thinking? There are lots of ways we can phrase questions and each phrasing may lead to a different possible response, no less the patient may or may not quite understand what we're asking.

Patients fear that they're going to be hospitalized, they're going to be secluded and put in restraints and they're going to be stigmatized. They have all sorts of beliefs that get in the way. Denial of ideation maybe the norm but suicide risk assessment has to go beyond that.

This is a study I'm currently working up data on; 157 suicides over many years for which I've been providing expert testimony. Suicide ideation I looked at specifically in terms of the last contact with the clinician almost half were seen within two days of their death and almost three quarters within a week of their death. Sixteen percent of clinicians, 16% of these 157 cases, the question about suicidal thoughts wasn't even asked. Where it was asked in 57% of the cases, it was denied.

Where it was asked and admitted to, there was almost an equal proportion of patients who said they had active ideation, I'm

thinking of killing myself versus passive ideation, I wish I were dead or I don't want to wake up tomorrow morning.

The standard of care requires clinicians to be reasonably competent and reasonably aware of what the literature tells us. What is really important to understand is that most clinicians believe that active ideation is more predictive of suicide risk, that is more predictive of suicidal behavior than passive ideation. But the literature, the research, does not support that.

When a patient is thinking about death, dying or suicide, they are at risk. But when they're not thinking about suicide, when they're denying that they're thinking about suicide what are the kinds of observations that might signal significant risk? Here are some examples from my 157 cases. Social isolation in about 60%. Anger, rage, irritability, seeking revenge, 47%. Anxiety, agitation almost 80%, three quarters of patients had significant signs of anxiety or agitation or sleep disturbance.

More than 80% had a history of suicide ideation or suicide attempt. Many had that suicide ideation or attempt as a reason for coming into a hospital and then denied suicide ideation as a reason to be discharged. Almost three quarters had significant interpersonal problems or job or financial strain. Same proportion for thoughts of hopelessness or catastrophic kinds of thoughts. Almost 80% had multiple psychiatric diagnosis.

That brings me to the Columbia Scale, which is the most popular, most frequently used scale for screening suicidal risk now in vogue. It's a good scale on many levels but it focuses on suicide ideation as an entry to a risk assessment and it has the problem of promoting active ideation as more significant for assessing suicide risk relative to passive ideation. Again the research simply doesn't support that approach. As Guidan's (Ph) article showed published just a couple years ago, Guttman Scaling is simply not appropriate for assessing suicidality, that is having a one to five scale. It's simply inappropriate.

A note about protective factors when we talk about assessment. Protective factors when there is acute risk simply don't protect. If I'm socially isolated, anxious, not sleeping, feeling trapped, feeling hopeless, the fact that I'm married, that I have kids, that I have a job doesn't matter. It's not in my brain. Protection works when there is chronic lifetime risk, not when there is significant acute risk.

Once assessment is completed, obviously a treatment plan must be developed and treatment must be implemented. A treatment plan and treatment should address modifiable acute risk factors, should not simply throw pills at the diagnosed problem or disorder, and should as is common in zero suicide implement evidence based treatments.

And where split treatment is being offered that is where there is a medicator, a psychopharmacologist or psychiatrist and a clinician such as a psychologist or social worker working with the same patient communicate frequently. Make sure that you're talking to each other because you each have observations of merit that will improve each other's work with the patient.

And where possible involve safety plans and safety contracts. Maximize continuity of care. Make sure the treatment also addresses the reasons one increases risk, that is what is happening to the patient on the outside that gave rise to suicidal thinking and may serve as a motivation. Feelings of guilt, shame, humiliation, embarrassment, feelings of failure, feeling trapped, feeling in essence that nobody loves me or facing potential legal actions and criminal complaints.

The treatment plan again must focus on protecting the patient from self-harm and therefore safety planning is an important approach. Make efforts at all possible to restrict access to means and to actively involve significant others notably family members in both the planning and follow-up after discharge from an inpatient environment.

Most importantly in zero suicide staff training is built into the model. There are two significant staff trainings that are available. There are others. These are the two I think are best. The AMSR, which the SPRC promotes which focuses on knowledge competencies and the AAS's RRSR which moves one step ahead of that and focuses on case application and behavioral competencies.

With that said, I know there's a lot more that could be said. I just want you to know that much of what I've said about assessment is embedded in two articles that were published by Mart Silvan (Ph) and myself on suicide and life-threatening behavior in 2014 and encapsulated in a chapter in the Nemerofen (Ph) [00:48:10] release and Cosgo's (Ph) book.

Thanks. I appreciate your attention.

>> JULIE GOLDSTEIN GRUMET: Lanny, thank you so much for an excellent presentation. We have all of these tools available to us but it's so important to know how best to utilize these tools. We have to be trained and we have to make sure that they are in best practice for really keeping patients safe so I think you really highlighted a lot of great examples.

I'm hoping the audience has an opportunity to highlight a couple of things that really stood out for them as well. Again, I know there's a lot of questions coming in. We'll do our best to get to them at the end of today's presentation. We do capture all these questions and so hopefully even if we can't get to them today we can continue to have this conversation after today.

So I see a couple of people saying things. I've always heard that contracting for safety is no longer recommended and safety plan should be the standard. Can you expand? So we'll have an opportunity during the Q&A to talk about that but we certainly know that contracting for safety does not hold anybody legally liable and it doesn't actually teach the patient the skills that they need to learn around safety and safety planning.

It was helpful people said to learn more about the CSSRS and potentially really ways to use it or thinking about protective factors and what does that actually mean with regard to acute risk.

Some great ideas about, I think a lot of people were really struck by that point that acute risk trumps protective factors and that we can't rely solely on assuming somebody won't make an attempt or die by suicide simply because they have protective factors available to them.

A lot of really great comments so I'm going to turn it over to our third and final speaker, Susan Stefan. And Susan is the author of *Rational Suicide, Irrational Laws: Examining Current Approaches to Suicide in Policy and Law*. So a recently published book from Oxford University Press. This examines case law relating to suicide including psychiatric malpractice, assisted suicides, right to refuse treatment, insurance and constitutional law.

Susan was a professor at the University of Miami School of Law. She's written three other books on the legal rights of people with psychiatric disabilities and litigated federal anti-discrimination cases across the country. Susan.

>> SUSAN STEFAN: Hi. It's an honor to be here and to be presenting with Lanny and Skip.

I have to say that when I was first asked to do this I engaged in a long and heartfelt email exchange with the zero suicide people about the name zero suicide because I was really afraid that the goal of zero suicide would just lead to more involuntary hospitalizations, fewer community passes and more coercion as providers focused on stopping suicide at all costs.

So I want to be clear that's not what zero suicide is about. It's about more coordination and a systemic approach instead of being ad hoc and reactive. It's about approaching suicide as a primary issue rather than framing suicidality as a symptom of mental illness. Zero suicide recognizes the importance of trauma and understanding people who are suicidal and zero suicide has actively involved suicide attempt survivors in their work. So I signed on.

I have to say that I would provide zero people wishing they were dead but that is nowhere near as catchy and it's also a lot harder to achieve. So before I start with generalizations, one of the things that I do want to say is that what we're talking about here is state law and state law varies tremendously from state to state. You need to know your own state's individual laws in these important areas.

So for example, in Delaware, mental health outpatient providers don't even have a duty to prevent their patient's suicide. In Mississippi negligence is not enough. The plaintiff must show that a provider committed an intentional act that lead to an irresistible impulse to commit suicide.

In many states like Iowa and Illinois, the negligence of the provider is compared to the so-called contributory negligence of the person who killed himself or herself or even worse that person's "contributory fault or comparative fault". I think this language really has to change. I prefer the term comparative responsibility or proportional responsibility.

One of the surprising things is that many state Supreme Courts are just now deciding issues of tremendous importance related to malpractice and suicide. For years for example Florida had ruled out provider liability for outpatient suicides but the Florida Supreme Court is deciding a case this year that may open the door for the first time to outpatient liability. At least four other state Supreme Courts have either just decided

or are about to decide very important cases on suicide and duty to warn.

There are obviously hundreds of these cases and I do discuss all the different state standards and causes of action and I look at hundreds of cases across the country in my book. But despite all of these differences in state law, some generalizations are possible.

What you need to hear and really understand is lawyers very rarely take suicide cases against providers. Although there are quite a few cases against jails and increasingly more cases against schools and universities. Certainly lawyers take suicide cases just because of the outcome.

What every single lawyer does is send for the records and goes through the records with a fine toothed comb. Many cases fall into a category I call ignoring the obvious. Ignoring the obvious is often reflected in either inadequate suicide assessments or risky medication practices. And again as you've heard over and over, no matter how good the care if it isn't written down it didn't happen.

So I want to talk about ways to reduce liability worries while providing better care in a variety of different environments. I want to start with inpatient facilities and systems. Look around. Look especially at environments where patients are most likely to be alone, meaning their bedrooms and bathrooms. Now most successful inpatient lawsuits are about environmental problems and fit into ignoring the obvious.

There's a case called Kirker (Ph) [00:54:56] where the court didn't even require the plaintiff to produce an expert witness. In the Kirker (Ph) case, a guy tried to hang himself from an exposed pipe in the ceiling of his room. When he came back from medical treatment for the first attempt he was put back into the same room with the same pipe. This time when he hanged himself he got permanent brain damage. The surprising thing to me was that this case was ever tried but you would be surprised how many cases there are out there similar in kind to the Kirker (Ph) case. It's not so extreme.

As Skip said, do not rely on 15 minute checks. There are so many cases, so many cases where the person was on 15 minute checks. First of all, if you even actually do them every 15 minutes they won't prevent suicides. Second, from my own 30 years of experience, 15 minute checks do not take place every 15

minutes. Sometimes it's a good thing because the element of unpredictability in 15 minute checks may be helpful but it's not a good thing when they don't take place for half an hour or an hour or two hours as has been shown by autopsies.

Basically 15 minute checks show that you, the inpatient hospital, were on notice that a person was suicidal and did something ineffective to prevent it. Being on notice whether from the individual himself or herself or a family member or another patient requires some kind of response.

And what I want to say is if you know that somebody is suicidal, what are you doing just observing them, just watching? I want you to imagine if somebody you really loved told you they wanted to die, would you just watch them all the time? Wouldn't you talk to them? Wouldn't you try and engage with them?

So I want to talk about the waves of the future because the field of suicide prevention is changing very rapidly and mostly for the better as the Zero Suicide Initiative and the Joint Commission Sentinel Alert illustrate, number 56. As the field changes, the standards will change and liability claims will change.

I'm seeing an increasing number of cases premised on the inpatient facility's responsibility to do the kind of discharge planning that ensures tight handoffs and at least some kind of coordination and follow-up. In 2016 alone, two state Supreme Court cases in Minnesota and Vermont were decided on the issues of facility's legal obligations post-discharge.

There was a recent case in Vermont, Kuligoski versus Brattleboro Retreat which rejects claims that there's a duty to the public at large to involuntarily commit somebody but does create a duty on discharge to inform caregivers about known risks of danger presented by a patient who is being discharged and ways to mitigate them.

So as the inpatient providers, I think when Lanny said contract for safety what he meant was safety planning, which is, I think, absolutely essential to have a safety plan, a crisis plan. Forget contracting for safety.

Don't punish patients for talking about suicide. If somebody tells you they're suicidal, don't take away their clothes or their pen or their stuffed animals or put them in seclusion or

take away their passes or their privileges. Then they won't talk to you about being suicidal anymore.

Think carefully about med changes when you're providing acute inpatient care. Talk to the family when the patient's agree.

I saw a question about consent. Yes, the patients have to consent. Sometimes the family is the problem, is the cause of people wanting to kill themselves. If you possibly can get past records and read them. Sometimes that's hard to do on a short stay but definitely talk to the patient's outpatient providers and consult on hard questions.

So the time of discharge is crucially important. Inquire about access to lethal means at home. And I can get you this. This should be on the Zero Suicide website.

The brief documentation of release, mitigation of risk is not yet another checklist that the patient has to respond to but it's a very helpful page and a half document created by the incomparable John Berlin (Ph) and myself. Make sure that you have considered everything that you need to consider before you discharge somebody and have documented it.

Listen to the family especially if a person is going home to the family. If you're an inpatient provider, chances are that the family knows this person better than you do. There's also another reason to listen closely to the family and that is if they're a primary cause for the person's wanting to die and you're sending that person back to that same environment.

And again, try to discharge somebody who has made a suicide attempt to community treatment that focuses on suicide and coping such as CAMS and DBT if at all possible.

So I talked to and surveyed almost 250 people who had made serious suicide attempts and their input as well as the available research as well as the Joint Commission's recent Sentinel Event Alert suggest that inpatient hospitalization is not always the best option even when somebody is very suicidal.

It can become a repetitive and life disrupting way of responding to extreme stress that does not teach the patient anything about her strength and her ability to cope. In some places, especially the Northeast, there are crisis alternatives to hospitalization including peer crisis alternatives.



By all means, review medication risks and benefits. A lot of outpatient malpractice case gets focused on medication. If the patient has, as with the case in Grease (Ph) [01:01:10] versus United States of America repeatedly tried to kill herself by overdosing on Seroquel. For God's sake, don't give her two months of Seroquel at the same time.

If the patient is known to be an active substance abuser, give it some thought before prescribing Xanax which is a drug that shows up over and over in cases involving the deaths of individuals known to be substance abusers.

Most of all, don't get angry at so-called needy patients because their accumulation of sadness and pain needs more than 50 minutes every two weeks. It's true that they need more than insurance will ever pay you to provide. It's true, they can't time their suicidal crisis to coincide with scheduled appointments.

They are not the problem. The system that will not pay you to give them the care they need and that leads you to constantly worry about liability is the problem. You and your patient are joint victims of an irrational and counterproductive system of care that both of you have to navigate as allies. You can work together and you can help that person as much as possible within the constraints that the system necessarily imposes on you.

So I would say the wave of the future for outpatient providers unfortunately in my view universal screening I think is happening. Never, never mistake screening for assessment. I don't think screening is necessarily good because I'm not sure the resources are out there once you do the screening.

I think less hospitalization is the wave of the future and safety plans, not contracts for safety, definitely more coordination among systems of care and directly targeting suicidality as opposed to considering it a symptom of mental illness.

Documentation you've heard about. The thing that I would say is most important is document both the pros and cons of your decision. Not only why you decided to do something but taking into consideration the reasons why it might not be a good idea and documenting those so that it shows on the record that you thought of the downside. Just record the downside and record the benefits and let us see your process of thinking.

Document using the patient's words as much as possible and all contacts. I know this. You've got a lot of paperwork. I'm suggesting paperwork but you'd be surprised how many times people call and leave messages on answering machines or talk to receptionists and it somehow doesn't show up in the record. All contacts should be documented.

Now I think that we need major systems change and zero suicide is a practical movement that deals with the world as we find it. And there are systems changes that would make it easier to implement many of the goals of zero suicide.

One of them is that we need to change insurance reimbursement for the treatments that are known to work with people who are suicidal. It is just, I think, absolutely unbelievable that we have evidence-based practices that insurance will not reimburse.

I also think we've made an enormous error by ignoring for years the input of people who have survived suicide attempts and have a lot to tell us about what works and what doesn't. One of the things that does work are peer suicide groups which operate more or less like AA and NA except without the religious stuff.

And I want to say when I say stop rewarding crisis I mean this on a variety of levels but at a social policy level we spend an enormous amount of money on crisis. We spend money on ERs and inpatient hospitalizations because it feels to me like we don't want to support people until they're right on the brink or falling over.

We don't help people struggling with problems like childhood sexual abuse and trauma or violence and poverty until they commit crimes or try to kill themselves and by then there's so much that has already been lost. It's like focusing on services for homeless people rather than people at risk of eviction. I know you have to do both but I know more universal prevention services would make it harder to do evidence-based research.

Nevertheless, I think the best approach to suicide prevention is a public health approach. The mental health community cannot do it all. We need to normalize suicidal feelings and focus on helping more people earlier, increasing both community and connection and emphasize not only saving lives but helping people to feel that their lives are worth living.

Thank you so much for coming and listening.

>> JULIE GOLDSTEIN GRUMET: Thank you so much, Susan. One of the things I love most about all of our presenters is they have such practical applications, such meaningful thoughts about how do we do this work better and how do we do it better quickly with so many great suggestions so I hope that all of you, your wheels are spinning.

Let's take a moment and kind of identify what you might have taken away from Susan's presentation before we move on to the larger Q&A. I see a lot of people typing.

Love this metaphor. Services for homeless people versus people at risk of eviction. I agree. I think it was such a poignant description of where should we spend our time so that we can truly impact suicide in this country.

I know that we have some issues around insurance reimbursement. A lot of people are really reflecting on 15 minute checks and how perhaps something that we've relied upon for a really long time really isn't state of the art and best practice. And that they're really going to have to go back and think about how best to ensure patient safety on inpatient units.

A lot of people talking about the idea paying attention to those who have made suicide attempts and talking to families. And for those of you kind of new to the zero suicide framework or suicide prevention community in general, I hope you realize the real efforts that have been made by people with lived experience.

There's really an incredible movement of ensuring that we have the voice of lived experience at the table. People who have been through the system. People who have struggled with thoughts of suicide. People who have lost loved ones to suicide. It's really important that they sit at the table as you're developing your policies, your approaches to care, your training, what works. Nothing about us without us.

So it's really important to know that there's a lot of people available to participate in this conversation. They're active on the Zero Suicide List Serve, on the AAS List Serve. And I hope that you'll really take that recommendation.

So a lot of great comments. A few people commenting on faith based and peer groups. Family and support system.

I'm going to move on, I think, to some of the questions that have come in because I know that the questions were popping up pretty rapidly.

I think the first thing I'd like to do and I'd like to point this to Lanny is if you could speak to the difference between a no harm contract or a no suicide contract and a safety plan. If you could expand on what is the best practice.

>> LANNY BERMAN: Yeah, thanks, and I apologize if I confused anybody by the wording on that slide. It is definitely true that no harm, no suicide contracts have no evidence of being of any value.

The term I used on the slide was safety contract. Clearly the term in vogue is safety planning but I think of it as stronger than that. I think that the safety contract is a documented charting that safety planning has been discussed with the patient and the patient understands and agrees to as best possible to try to follow the steps that have been outlined in the safety planning. But I think truly I confused people by using the word contract.

Just to add to that, I think it's helpful within the same therapeutic structure to use what David Rudd has written about called *The Commitment To Treatment*, which is a way to try to engage the patient as best possible around compliance and adherence.

One of the great difficulties we have and what's truly descriptive of people most at risk for suicide is that they are not our best patients if you will. They don't comply. They don't always adhere to medication. They simply are difficult to treat patients and the more we can engage them on committing to treatment and committing to safety planning the better. And I like to see that documented so I apologize for the confusion again.

>> JULIE GOLDSTEIN GRUMET: Thank you, Lanny. Another question I saw come in was about HIPAA and somebody had asked you can only legally break confidentiality when the risk of harm to self or others is imminent. So how should providers manage when the risk is high but not imminent and the client doesn't consent to collateral contact? I think maybe we'll start with Skip.

>> SKIP SIMPSON: Yeah so my thought is on this confidentiality issue and imminent, I don't know what imminent means. No one

else knows what imminent means. Does it mean in the next five minutes, next five days? What does that mean?

So what you have to do is go ahead and find out from your collaterals what's going on, other prior caregivers and if the California law is written in a way that gives you wiggle room, which I think it would have to be, then I would go ahead and do what you have to do to keep a patient safe.

And I cannot imagine anyone suing anyone for breach of confidentiality on HIPAA. It's very, very tempting for me to say, and I will say, that if anyone in California gets sued for that particular issue I'm inclined to defend you for free.

>> JULIE GOLDSTEIN GRUMET: Well thanks, Skip. I think if you or either any of the presenters from today might want to elaborate it sounds like eminence is it always defined as something self-destructive or lethal in the next 24 to 48 hours? What does that mean legally? Is that truly the timeframe legally? What about in terms of foreseeability? So how do the clinicians on the call today or systems on the call today use the idea of imminent in order to improve their practices or their accessibility to breaking HIPAA? Or I shouldn't say breaking HIPAA but utilizing HIPAA in order to keep people safe.

>> SKIP SIMPSON: Right so Bob Simon wrote a very good article on what does imminent really mean. There is no definition of what imminent means out there. And so that's another one of those little things that can hurt us when we're trying to protect our patients.

What I want you to understand in my mind is don't let the law keep you from protecting your patients. There's nothing in the law that should be doing that and so for you California folks, I know I've had some of those conversations before. Feel free to call me or email me at [SSimpson@SkipSimpson.com](mailto:SSimpson@SkipSimpson.com) and I would be glad to address those questions specifically for my California friends.

>> JULIE GOLDSTEIN GRUMET: Thank you, Skip.

>> LANNY BERMAN: Let me just add to that.

>> JULIE GOLDSTEIN GRUMET: Oh go ahead.

>> LANNY BERMAN: As Skip said, there is no clear definition of imminent and I think from the law's perspective, the primary issue is not so much imminent but it is proximate.

And proximate means in effect that your behavior as a clinician if there's an act of omission or commission is a significant link on the chain that ultimately led to the suicide.

I've dealt with cases that where the suicide occurred literally eight or nine months after the clinician saw the patient but because of the clinician's behavior there was a malpractice action implemented.

>> JULIE GOLDSTEIN GRUMET: Susan.

>> SUSAN STEFAN: Well there are states that do define imminent. I want to go back to my comment that you need to know your state law. And in my book I actually have in chapter two various states either statutory or case law definitions of eminence. That is for commitment purposes.

Eminence for the HIPAA purposes what I would say is there is on the HIPAA website, the government's HIPAA website a frequently asked question, question and answer specifically about confidentiality in the context of patient's who may be dangerous to themselves or others. And I believe that if you sincerely and professionally believe that contacting collaterals that are very close to and know this person will basically help you save the person's life in the moment, in the day.

As Skip said, nothing is going to happen to you. One of the things I'm seeing more and more in the recent Vermont Supreme Court case that I cited to, the court basically, the defendant came in and cited confidentiality as reasons for not telling parents about the risk presented by their child who they were discharging the child to the parent's custody.

The court said no, like we're not really concerned with confidentiality. I'm seeing more and more Supreme Courts if they've got a way danger versus confidentiality, confidentiality is losing. That may or may not be a good thing but I've got to echo Skip on this one.

>> JULIE GOLDSTEIN GRUMET: Great. Thank you, Susan. I also want to remind you that there's a parallel conversation about a lot of this going on Twitter with hashtag Zero Suicide so for those of you on Twitter, you may find that a lot of people are already posting resources.

Diane, if you could bring up the resource document that we have. People can download a lot of resources that have already come up. You see this square box that says legal and liability issues suggested readings. You can upload the file to your computer now. As far as the archives, this will be available with the archive as well but we ask the presenters to share with us many of the resources that they mentioned today or things they thought that would be helpful.

I think another question that I'd like to refer to that several people asked about assessing for suicide, in particular if the individual is denying suicidal ideation or having red flags. Lanny, we'll start with you. Do you have any recommendations about assessing for suicide especially if the individual continues to deny suicidal ideation? What could a clinician use? What might next steps be and Susan and Skip, if you have some thoughts on this I welcome those as well but Lanny, let's start with you.

>> LANNY BERMAN: Well it's clearly a difficult question to answer. The primary issue is understanding what the research tells us about risk. Most all risk factors and there are perhaps 50 or 60 empirically defined research based risk factors are chronic risk factors. That is they're associated with elevated risk over the patient's life.

What we really need a great deal more research on is short term, near term, acute risk factors that otherwise point to warning signs. A few years ago as most people online probably know, we developed the is path warm acronym for acute risk factors. That is not meant to convey all that is known about near term but the reality is that we know very little about risk factors associated with suicide in the next 24 hours, 48 hours, even seven days.

There is practically no research. In fact I just spoke with someone the other day who did a macro analytic study of all research articles on this and said there are only two studies in the literature that have looked at suicide within 30 days of death where the outcome was suicide. Not suicide attempt or more suicide ideation. So we simply lack the research.

What I put on my slides were some of the beginning thoughts and clearly these need to be further explicated. But some beginning thoughts about understanding that we need to get within the skin and see through the eyes of our patients and understand that whether or not they're saying they are thinking about suicide.

Is there enough anguish, enough despair, enough hurt going on that it's reasonable to think that they might consider suicide whether or not they're telling us that. And if so simply to act in accordance to develop treatment plans and implement those to deal with everything that gives rise to that sense of anguish, that sense of hurt, that sense of pain, that sense of feeling trapped, that sense of potentially wanting out.

>> SKIP SIMPSON: This is Skip. One of the things I would say again is looking at Shea's suicide assessment, there's techniques on how to get people to talk about things they don't want to talk about.

So one of the things you'd want to do is normalize for that patient look I have lots of people that come into me with the very same kinds of symptoms that you have, depression or anxious and when you have thoughts like that, surely you may be thinking about suicide. I know most of my patients do. Tell me about some of your thoughts that you've had.

Just think of ways to get people to talk about things they don't want to talk about. Physicians have to do that all the time whether they're talking about sexual issues, whether they're talking about drug issues, whether they're talking about suicide. There are techniques to get people to talk. It's an interviewing technique. Those things can be easily found in the books that I've mentioned. Thank you.

>> JULIE GOLDSTEIN GRUMET: And you know that Skip is a lawyer, not a clinician, but I think that clearly his clinical acumen and his passion for this comes through.

I think one of the questions that came up that makes I think really attaches onto what you're saying Skip and others, I want to go back to the HIPAA point, which is how do you navigate breaching confidentiality to consult with collaterals? What are some suggestions you all have to navigate that with the patient?

>> SUSAN STEFAN: Can I just interrupt and say that collaterals are -- you definitely need to talk to people. Sometimes the



family is the problem so you definitely need to listen to them but to be aware sometimes the family is the best of all possible worlds and a great support system but sometimes people are rightly afraid of their family members. So definitely talk to the therapists, the providers with the client's consent but you need to know what the relationship is with the family. Sometimes the family is great and I'm not making generalizations either way but I just wanted to jump in and say that.

>> JULIE GOLDSTEIN GRUMET: Absolutely.

>> SKIP SIMPSON: No, I agree with what Susan is saying. This is Skip. I agree with that. One of the things that you might talk to your patient about is that we're here to save you. We're here to help you and it's going to be helpful for us to have family members as a part of the treatment team so that we're all working together to save you. Is that okay?

That's a good way to avoid the whole HIPAA issue is by getting people to agree to the confidentiality issue. These are the people that you can talk to and I'm okay with. That way you don't have a HIPAA issue. You now have laid the groundwork so you can talk to collaterals.

>> JULIE GOLDSTEIN GRUMET: Great. Thank you. So I see that we're at the end of our time. I do hope that this conversation will continue. We do have a very active List Serve. You can sign-up for the Zero Suicide List Serve at [ZeroSuicide.com](http://ZeroSuicide.com) under the get involved button. I hope that you'll join us.

There's a lot of other questions I'm so sorry we didn't get to today but I really hope this stimulated a lot of thinking on your parts about how to enhance care in your systems and how to do so in such a way that does not put you at risk for liability.

I heard a lot of wonderful practical suggestions and again the passion and the commitment that came from our three presenters I think was so present and palpable. I can't thank them enough for joining us today on this webinar.