Legal Liability in Suicide Care and the Courage to Change Institutional Culture

JASPR Health Webinar

March 25, 2021

Susan Stefan

Purposes of This Presentation:

- 1. Encourage mental health professionals not to involuntarily hospitalize suicidal patients because of fear of liability
- 2. Encourage mental health professionals to replace involuntary hospitalization with more beneficial approaches
- 3. Encourage mental health professionals to transform care of suicidal patients to be more focused on improving patients' quality of life than preventing suicide.

Purposes of this Presentation (cont.)

- Encourage health care organizations to focus on practices that improve care for people who are suicidal while reducing risk of liability
- Start a conversation on how to transform systems of care to better serve suicidal people

I. Individual Health Care Providers

A. One of the Best Protections Against Liability is to Forget About Liability

- 1. Concern about Liability Creates Adversarial Relationship Between Professional and Patient
- 2. Patients Focused on Whether Professional "Really Cares" About Them
- 3. Suicide is Rare. Litigation is More Rare. Successful Litigation is Even More Rare.

Suicide Malpractice Cases Often Involve Mind-Boggling Levels of Negligence

- Doctor withdraws from medical practice without informing suicidal patient; when patient's condition deteriorates and he tries to contact doctor, medical practice cancels or postpones appointments w/o telling patient why. Johnston v. Kim Barkley Webster (Oregon 2001)
- ER Fails to Assess 20 Year Old for Suicidal Risk When He is Taken to ER Following Suicide Attempt. Schmitter v. Samaritan Health Services (Oregon 2017)

Best Protection: Care About Your Suicidal Patients and Do the Best You Can For Them

- 1. **Avoid involuntary hospitalization if possible**
- a. Suicidal people Report Little Benefit/Much Harm from Involuntary Hospitalization
- b. The Research Backs Them Up
- c. Chronic/Acute Suicidality
  - Importance of this Distinction for EMTALA purposes
- Exceptions: the ICU/Heart Attack Rule

From a suicidal person I interviewed

- **“It may feel less risky to forcibly hospitalize someone who mentions a desire to hurt themselves, but this risk must be weighed against the risk that acting against the will of a person who already feels hopeless is likely to accomplish little more than causing more self-destructive thoughts and encouraging that person to remain silent about such thoughts in the future.”**

What You Can Do Instead of Inpatient Hospitalization

- 2. **Therapy Targeted at Suicidal Drivers** (CAMS, CBT, DBT) Including those adapted for ERs
- a. Suicidal People Prefer Directly Dealing with Drivers of Suicidality: Listen to Them
- b. Research Backs Them Up
- c. So does Joint Commission and CMS
- d. Targeted Therapy: New standard of care?

What You Can Do Instead of Involuntary Inpatient Hospitalization

- Be Aware of the Vast Array of Potential Community Support Beyond You:
  - Peer Support Systems
  - Church
  - Some (not all) VNAs
  - Affinity group support systems
  - Warm lines, Live Through This, To Write Love on Her Arms
- Share Responsibility with Competent Adult Patients (Rudd and Joiner 2012)

What Suicidal People Said They Need

- **Need to speak freely without fear of involuntary hospitalization**:
- "When people say they're suicidal, that stops the conversation. They immediately go into crisis mode: 'Let's pack her off to the next level of care, because I am not equipped to deal with this.' Why can't they say, 'this must be a terrible feeling, what do you mean by saying you feel suicidal?'"
- **Need to have suicidality seen as response to trauma/life stressors/loss, not mental illness**
- "People don't consider stable housing and access to food and job finding as mental health assistance. I definitely wish that was an option for me."

What You Can Do Instead of Inpatient Hospitalization

- **Framework Shifting:**
- Change from Suicide Prevention to Coping With Pain that Makes Suicide an Option/Changing Life
- Change from Equating Suicidality with Incompetence to Partnering with Competent People in Pain: Informed Consent & Suicidal Patients
- Understand the Purpose of Chronic Suicidality

Many things are helpful to your client and protective against liability. DO:

- Inquire About Access to Lethal Means
- Have Crisis Plan/Crisis Communication Policy in Place Prior to Crisis
- Attend Carefully to Transitions
- Communicate if Possible with Relevant Others
- Take Thoughtful Risks To Empower Your Patient
- Document All of the Above

DON'T

- Contract for Safety
- Let Your Feelings of Powerlessness or Time Pressure Stop You From Trying to Do the Right Thing for Your Patient
- Blame the patient. Your suicidal patient is not the problem: the broken system of healthcare in this country is the problem

Individual Mental Health Providers: Liability Clusters

- A. MEDICATION ISSUES
- 1. Prescribing New Meds Without In-Person Eval
- 2. Prescribing Too Many Refills
- 3. Failing to Account for Known Substance Abuse
- 4. Failing to Follow Up on Complaints of Side Effects or Worsening Symptoms
- Parton v. Jeans (Ariz.App. 2019); Thompson v. Pediatrics Cool Care (Tx.App. 2019)

Liability Clusters for Individual Mental Health Professionals (Inpatient)

- Inadequate Communication/Coordination
- Inadequate Discharge Planning/Followup
- Do NOT Rely on 15 Minute Checks
- Almost all Litigation marked by Inadequate/Contradictory/Falsified Records

Liability Clusters for Individual Mental Health Professionals (Inpatient)

- **DOCUMENTATION IS ILLEGIBLE OR**
- **EHR DOCUMENTATION IS "CUT AND PASTE"**
- "Dr. Moore testified that 'there are many records made in the medical records that are not fact.' He further described some of the records as "medical record notes that were cut and paste, whether they were done by an intern or medical assistant * * *." Cappuccilli v. Carcieri, 274 A.3d 722(R.I. 2017)

MOST COMMON PITFALLS (cont.)

- 2. **DOCUMENTATION IS FALSIFIED OR ERRONEOUS**
- A. Fifteen minute checks or bed checks

  Doe v. Hospital (Utah confid. Settlement 2011)(pt.dead for hours; nurses admit they just looked through window for bed check)

B. Later documentation recorded as though it was contemporaneous

MOST COMMON PITFALLS (cont.)

- 3. **DISCONNECT BETWEEN FACTS IN RECORDS AND TX PLAN/PROVIDER RESPONSE**
- "In a morning group session run by LT, … he reported that he had suicidal thoughts that morning and considered staying home and overdosing on medication. The medical record does not indicate that Ms. T took any action after Mr. C reported these suicidal thoughts with a plan of taking an overdose of medication that he had contemplated putting into effect that very morning. "
- D.C. v. Cimpeanu, No. 10-00830H (Mass. Super. Offer of Proof, 12/2011)

MOST COMMON PITFALLS:

- 4. **Missing or incomplete documentation, especially of key issues:** instructions to patient and family, inquiries about access to lethal means, informed consent about medication, competence to consent to treatment, med errors
- Lane v. Provo Rehab (nurse's falsification of records related to her medication error imputed to nursing facility)

How to decide and document close calls on involuntary detention

- Suicide: Impossible to predict, can only assess risk, involuntary detention disrupts and damages treatment relationship
- Recognizing, assessing, and documenting risk≠ involuntary detention
- Using research (trauma, epidemiology) to support decisions to avoid involuntary hospitalization
- Assistance in deciding and documenting: BDR-MOR (tool for ER discharge decisions)
- Do not rely on “contracts for safety”

A Few Words About Suicidal Children and Adolescents

1. Statistically less likely to kill themselves
2. Be wary about prescribing off-label psych medications for suicidal children and adolescents
3. HIPAA Clarifications: You have to know your State's confidentiality laws and Federal laws relating to Substance Abuse confidentiality

Health Care Systems

- **Five Most Important Steps**
- 1. Environmental Audit
- 2. Policies Ensuring Coordination, Communication and Continuity, esp. relating to EHR
- 3. Recognize and reward staff who excel in assisting people with psych disabilities
- 4. Be extremely careful to ensure robust discharge planning and followup after transitions
- 5. If you have outside evaluators doing ED psych evals, make sure they are practicing within scope of practice

Making Change in a Resistant Organization

- The Story of Anaesthesia…The Story of Sterilizing Before Surgery…and many more
- Have specific goals
- Find allies, both inside and outside of the organization
- Document differences of opinion
- Exhaustion does not come from working long hours. Exhaustion comes from feeling frustrated & discouraged that your work lacks purpose or meaning, that you are powerless or just treading water. Doing work that has meaning is—mostly-- energizing, not exhausting.

QUESTIONS?

- If I do not get a chance to answer your questions, please email questions for me to Marcus.kako@jasprhealth.com
- The Bibliography for this talk will also be posted at JASPR's website.
- THANK YOU!!