Jaspr Health Webinar

Addressing Legal Liability & Culture Change:
The Courage to Improve Care for Suicide Crises in the ED

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Legal Liability in Suicide Care and the Courage to Change Institutional Culture
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Kelly Koerner: Welcome. I'm Kelly Koerner, CEO and host of the JASPR Health Webinar Series. Susan Stefan works with patients with psychiatric disabilities. That's what we'll talk about today. IMH is a digital platform to scale suicide care. Susan, I'm struck by this combination of legal expertise and deep empathy of scholarship around patient experience, and this extensive way of expanding this work, and the courage it takes to provide patients with the best possible care. Thank you for joining us.

Susan Stefan: Thank you. I'm excited to be here. Thank you to Marcus Kako for putting it together and thank you for having real-time captioning.

There! I'm on the purpose of my presentation! We must encourage mental health professionals to not engage in involuntary hospitalization but encourage approaches that are more beneficial long term. We'll talk about what those approaches might be.

I think that mental health professionals are very focused on preventing death. But I'd like someone to start focusing on why people are suicidal in the first place. It's about quality of life. I'm not original in this thought. DBT programs do that as well. I'm happy to report that Indiana has a new plan released in January 2021. They've now stated that Indiana will move beyond a focus of zero rate of suicide to a broader endeavor. That will be beneficial to mental health professionals and suicidal people.

I argue that mental health professionals shouldn't focus so much on liability. In fact, you shouldn't worry about it at all. I'm also presenting today to healthcare organizations. There are many things that impact healthcare organizations around suicidality. We'll talk about that.

Finally, I want to talk about how hard it is to transform systems of care to better serve suicidal people. This is very difficult, even when you empirically know that an approach works better and saves more lives.

I'll start by addressing the individual healthcare providers out there. Paradoxically, one of the best protections against liability is to forget about it. There are several reasons about that.

I put all the studies in the slides, but there were a lot of them. I'll send a bibliography to Kelly and she'll post it on the JASPR website. When I say that there are research reports or studies, I'll key the bibliography with those slides.

Medical professionals who are most concerned about liability have the tendency to be sued

more. If you're looking at your patient as a potential plaintiff, it's hard to have an alliance. It's more of an adversarial relationship. Patients are highly sensitive to that. I interviewed almost 400 people for my book. What struck me was the patients felt and wondered if the professionals actually care about them.

Sometimes, professionals felt like hospitalization was an indifferent solution to the patient's pain. I would argue that in those cases, you still don't have to involuntarily hospitalize.

But empirically, you don't have to worry about liability because of the numbers. Suicide is incredibly rare. 99.6% (according to the CDC in 2019) of people with suicidal thoughts don't take their own lives. Even if you look at people who have made suicide attempts, 97% of people who made attempts don't end up killing themselves.

Secondly, most suicides don't result in malpractice cases because they can't. A majority of people who kill themselves are not in contact with any mental health professionals when they do it. At the time of death, 57% of people who killed themselves never had any contact with the mental health system, and 61% were not seeking treatment.

Finally, and what I think is most important and what mental health professionals don't realize, there are very few people who actually get sued. And a fair number of those get sued a lot. 1% of physicians account for 32% of all malpractice claims. Think about that.

Psychiatrists are 4% of doctors but only 1% of malpractice claims.

I have a web-based reporting of suicide attempts reported as suicide malpractice cases. It averages about 70 a year. It's really rare so you can forget about it.

Also, the cases involved mind-boggling levels of negligence. I imagine most people on this call can't even fathom it. I'll give you a few examples, and we'll discuss a few more throughout this presentation.

A doctor with a patient who was suicidal left the medical practice and didn't tell the patient. The patient kept trying to make an appointment and the office kept canceling and wouldn't tell her why.

There were people taken to the ER for attempted suicide, and the ER doesn't do a risk assessment for suicide.

As a provider, you can show that you genuinely care about your patients and not worry about liability.

What is doing "the very best you can?" I think it is very important to avoid involuntary

hospitalization when at all possible. When I did my surveys of people, as you might imagine, suicidal people are all over the map about what the cause is, and whether they have a mental illness or not. But, across the board, people said involuntary hospitalization was not helpful for a variety of reasons. They said that there was now targeted treatment for their suicidality. When they brought it up, they were told that was only for outpatient. Many told me, they didn't belong there.

The research backs up the interview results I got. There's no real benefit to involuntary hospitalization, and there's a fair amount of evidence show it's harmful, or at least doesn't have beneficial results.

I had someone reach out to me about a 3-hour presentation on EMTALA. Professionals need to pay attention to documenting the difference between acute and chronic suicidality. Chronic suicidality is a base state for some people who can go through this for a long time. I had a patient saying she would kill herself for 15 years. Chronic suicidality is actually in some ways a coping mechanism. It is not acute.

One of the things about EMTALA is EMTALA requires for an emergency a medical condition manifesting itself by acute symptoms of sufficient severity, including pain and psychiatric problems which could put the patient in danger to damage to bodily functions.

One thing you can do is compare the presentation to some kind of baseline. There's research on doing that. When you document, you make sure you compare people's suicidality to their general level of suicidality and be very alert for acute, situational exacerbations.

One of the things I want to be clear about is, I'm not saying never ever involuntarily hospitalize anybody. Two of the psychiatrists I respect the most have verbalized, how do you know? It is damaging. It is harmful. One doctor, Dr. Robert Factor in Wisconsin, said it like this. If I'm going to coerce, or force someone to do something they wouldn't do by themselves, I don't think about "does this person need to be hospitalized," but "does this person need the ICU?"

Another doctor said, people are hospitalized for chest pain. 85% of them don't have heart attacks. But it's not involuntary. He said, "I don't hospitalize people who are having the equivalent of chest pain. I hospitalize people who are having the equivalent of a heart attack." I thought that was an interesting comparison.

This quote shows that you may think you're reducing short-term risk, but you're really increasing long-term risk. Joel Paris wrote a book about that. An old book by Dawson & Macmillan in 1993, argues that hospitalization increases long-term the risk of suicide of people diagnosed with borderline personality disorder.

So, what do you do instead? The evidence for therapy targeted at suicidal drivers is very strong.

For instance, the JASPR model targets these suicide drivers in the ER. But it's a good model. They didn't ask me to say that.

When I talk to people who are suicidal, they prefer this because it's respectful. That's what's driving them. Their focus is their suicidality. To essentially be told they're mentally ill is discouraging and frustrating. It doesn't mean some people aren't mentally ill. I know someone who has schizophrenia who isn't suicidal. That's a person who I would say, yes, the mental illness needs to be treated to treat the suicidality. But I don't think that model works for many people who are suicidal.

This model is the way to go, and I'm pushing hard for it to be the new standard of care. It's not the standard of care yet. When I talk to my friend Skip Simpson, for example, who is a lawyer who does malpractice suits, says, "you want me to sue someone for malpractice and not doing targeted therapy when the patient says, 'I'm going to kill myself' and the therapist says, 'Let's get back to that next week.'." So, we really need to prepare for that in the future.

If I get no other message across, it's this: this is not all on you. There is a vast array of community support that can help people. It's a terrifying and illusory belief that mental health professionals have, and it's sometimes transmitted to the public, that if there's a suicide, the mental health professionals are always somewhat responsible. Except for people who are clearly intoxicated or clearly incompetent. People who are suicidal are generally competent. The law recognizes that in most states by allowing the jury of involved in the suicide of an outpatient to consider informed consent. I agree with Rudd and Joiner that informed consent should play a much bigger role.

There is the nature of risks. The shared responsibility in suicide treatment can reduce risks. The mental health professionals can't go to your house and make sure your guns are locked in a safe, for example. There's a shared responsibility here.

For people who are afraid of having that conversation, the overwhelming message I heard is this. People who are suicidal want to feel like their mental health professionals care about them. They don't want involuntary hospitalization. They want to be able to speak freely about their suicidality without fear of being hospitalized.

One of the most moving interviews I had was with a woman. I start talking to my mental health professional about my suicide, and the professional acted so scared that I thought, wow, I must really be in a bad place. It's very scary. It's important to understand that people who are suicidal feel like they have no control over their lives. They feel disempowered. There are few things you could do. If you had a goal of making someone feeling like they have absolutely no control over their lives, like they have no power, involuntarily containing them against their will is probably one of the good ways to make people feel powerless and hopeless.

People also said that they'd be angry and frustrated when it's said that we need to find a

diagnosis here, when they're 10 days to being evicted, and they can't pay their rent and don't see a way out of this. So, we need to recognize these suicidal drivers as problems and barriers in a person's life.

Like the state of Indiana, I very much have supported framework shifting. A lot of people have talked to me and said, my therapist just didn't want me to kill myself and was afraid about it but didn't really care about why I was so miserable. Change this equating of suicidality to incompetence -- you cannot equate suicidality with a lack of competence to make medical decisions. So, understand that the person you're seeing is competent. Treat them that way. Partner with them.

And finally, understand the purpose of chronic suicidality. Chronic suicidality does a lot of things for people. It keeps options open in a way that, in some ways, helps people stay alive. They think, "I could always kill myself." It communicates the severity of the person's distress, discomfort, and pain.

One of the things people said helped them was when the therapist said, "Look, this is an outpatient situation and I can't stop you from killing yourself. But give yourself 2 weeks. You could always do it but give yourself 2 weeks." One of the things that enraged people when they heard it was "suicide is a permanent solution to a temporary problem" because when you're in there, it doesn't feel like a temporary problem. It feels like that statement minimizes my problems and my pain.

So, chronic suicidality, I understand. I have a number of clients who I sometimes think of as acutely chronically suicidal. People will literally email me and say, "tonight's the night, I'm going to do It." I always make it clear to people, you can talk to me and say anything you want, and I will not call 9-1-1. I have had bloodcurdling suicide threats. Not a single person who has done that even attempted suicide.

I had four clients who have killed themselves. In those cases, I had no warning. They didn't say a word, and their life circumstances didn't give me a thought or warning.

By all means, do these things. These aren't coercive. It's not coercive to inquire about access to lethal means. It's important and caring. And one thing I think is now pretty close to being a standard of care is having a safety plan and having a crisis communication policy in place prior to a crisis.

I understand that many of you have to set boundaries. I don't like that phrase, but it makes sense. It's helpful to set out your policies to people when you first meet them so it doesn't feel like a personal rejection. When you start out by saying, "I don't take calls on the weekend, but if it's an emergency, do this." Whatever it's going to be, communicate your crisis communication policy right at the start. If you can get a safety plan going, you should.

Everyone should attend carefully to transitions to care. The time period immediately after discharge from the hospital is a risky time. Research shows that. People are conflicted about why that might be the case. Also, going into the hospital, just like someone going to jail, especially for involuntary hospitalization, look hard and pay close attention to those transitions of care.

Communicate, if your patient lets you, with adults you need permission. But it's helpful to get more perspective.

Take thoughtful risks that empower your patient and document all of the above. I have a bunch of slides about documentation.

Do not contract for safety. It's not only unhelpful, it's probably harmful if the person ends up killing themselves and there's a lawsuit. It just doesn't work. The research shows that.

I know that you can feel both real genuine time pressure and also feelings of powerlessness. Don't let those things stop you from trying to figure out what the right thing to do is, to help somebody who is so miserable, they're thinking death and extinction would be better than their current lives. I know it's easy to feel impatient or exasperated. But, the patient is not the problem. I could spend hours talking about the way insurance companies disincentivize the best treatments for people who are suicidal.

The ways of the public health approach are disincentivized. The system is a mess. And you and your patient should collaborate as allies, making your way through the maze of barriers and obstructions to helping this suicidal person. Really, the problems you have with them are really problems created by the structure of the system.

When I say don't worry about liability for involuntary hospitalization of somebody, what should you worry about liability for? There are clusters. One of the big clusters is medication issues.

If you're watching this and you don't have the power to write prescriptions, good for you. You have just opted out of a big chunk of the lawsuits that get brought. There are many more case citations than the ones I have here. There was a Supreme Court case versus a primary care physician. Prescribing new medication to someone who is psychiatrically unstable is not a great idea. Prescribing too many refills at once is problematic. When you know someone has the history of a substance abuse disorder, prescribing someone medications that, when mixed with other substances, can be fatal, it's about someone who may not even want to die, but it may be about overdosing.

Failing to follow up from very clear calls for help about the medication not working or the medication having terrible side effects.

Another cluster is around inadequate communication. I was shocked by this. Going to primary care practices and always seeing a different person. If you're a healthcare organization watching this and you have someone who has suicide potential, and every time they go to the practice, they see someone different, you have communication and coordination challenges that you should be on top of. Increasingly, the two kind of "trendy" areas in licensing, certification, and liability are these transitions of care, like inadequate transition and follow up, and mind-boggling malpractice cases where someone tried to hang himself over an exposed pipe over his bed, in the hospital. They took him to a different hospital, then eventually brought him back to the same room and he did successfully hang himself. That was a big lawsuit.

One of the things I've found as a practicing attorney is the 15-minute check record. That's probably the most commonly falsified record. People can hang themselves in 7 minutes flat. And my interviewees told me that they're very attuned to the schedule of 15-minute checks.

So, almost all litigation, especially successful litigation, is marked by inadequate, contradictory, or falsified records.

This is an actual quote from a case. Not helpful, actually. It's not helpful when the doctor says, "there are records in the medical records that are not fact" because he says quite truthfully "many medical records are copied and pasted." It's true. I've worked with these. You get a patient's record who is a male, but because of cutting and pasting, the male patient and referred to as "she" and so on.

If I'm doing a lawsuit, I like to be able to point out that the record keeping was so slipshod, they couldn't even get the gender right.

Falsified documentation is more common than you think. You pretty much should just get out the checkbook. I worked for a hospital where they made 15-minute checks for 6 hours after the woman was dead on the floor. That's not good.

Falsifying includes when you're falsifying the time. I can speak for myself. I cross-check times of important things, important records, to see whether this person was there at that time, or are they recorded as being somewhere else? And later, documentation may not have anything to do with the quality of care, but it calls the rest of the records into question.

This is a little more nuanced. When there's a disconnect between the facts of the records and the plans of response, or the provider's response, here's the record correctly showing that DC told the leader of the group session that he had suicidal thoughts, and he considered staying home and overdosing on medication. And the person running the group session took no action whatsoever. And he then returned home and overdosed on medication, as he said he might do.

Another one missing documentation, especially about key issues. In some cases, if a nurse or a

staff person does this, those actions are imputed to the facility.

So, there are times where you don't want to hospitalize someone, but you're worried. As I said, you shouldn't engage in involuntary hospitalization if you can help it. So, how do you avoid involuntary hospitalization?

One thing, in your documentation, you can discuss the degree to which involuntary hospitalization could disrupt your relationship with the patient, which in the long run, could increase suicidality. Documenting the risk in detail shows that you went through a process of professional judgment. Trying to conceal the risks you're considering is not the way to go. There is research that for certain groups of people like patients with borderline personality disorder, people with trauma histories -- there is some conflict with people that I've talked to. I think epidemiology is helpful. If you're seeing a young Hispanic woman in Massachusetts, the chance of that person killing themselves, epidemiologically, is extremely low compared to a middle-aged white guy who was just divorced. I think it's helpful, but there's some conflict there.

Dr. John Berlin and I developed a tool you can use to show that you've considered all the salient factors. It's called BDR-MOR. I can send it to you if you want it. Don't rely on contracts for safety, please.

Kids, children, and minors create a whole different set of issues. I had a question ahead of time for somebody in Oregon who asked about parental involvement in mental health care, including safety planning. There's a complex intertwining of federal regulations and state law when it comes to minors and mental health and minors and substance abuse. I'll run over it briefly, but if the person who asked wants to follow up with me, I'm glad to do that.

In Oregon, a minor 14 years or older can access mental health services or chemical dependence services without parental approval. With few exceptions, parents are expected to be involved in their treatment at some point. But, with regard to substance abuse, if minors are given consent to treatment by the State (in Oregon's case, 14 years or over), then the minor's treatment records can't be disclosed without the minor's written consent, including to the parent or guardian.

This is obviously going to vary state by state. In Massachusetts, it's 16, I believe, when a minor can consent independently. Involvement doesn't always mean access to records. If the mental health professionals conclude that there are issues to the contrary, the parents should not be included in the treatment.

That's giving you an idea of confidentiality issues between HIPAA and state law. I would caution you about giving medication to children and adolescents. Monitor this carefully if you're doing this. Follow up.

I want to also get to healthcare systems. I've been trying to say to individual healthcare

professionals, please avoid involuntary hospitalization if at all possible. Your treatment and your own peace of mind will be improved if you can just forget about liability. Your legal liability, especially as an outpatient therapist, your risk, is close to nil. Your chances of being hit by lightning in Maine are greater than being sued for malpractice. So really, forget about liability. Document well. And care about your patients.

For healthcare systems, I don't have that advice. There are things going on, the joint commission in 2019 came out with new requirements which have also been echoed elsewhere. I agree with these, in the sense that generally, environmental audit means to look for things like exposed pipes and breakaway shower rods.

One conversation I had with hospitals, which is distressing and I recommend against, is setting aside cubicles for the psych patients. I saw this with my own eyes. The cubicle for psychiatric patients had a concrete floor with a drain in it. In another hospital, there was a bed with leather restraints attached to the four corners.

So, there's a limit. An environmental audit shouldn't be a stigmatizing room. One hospital did it very well. There was a pull-down door where they could conceal the machinery if they had a psychiatric patient there.

The psych patients didn't have televisions in another hospital. I didn't understand that because the televisions were high on the wall.

Don't just listen to what I'm saying. The joint commission recommends the design guide for mental health facilities. The VA has guidelines, too.

Kelly Koerner: Susan, we have about 10 minutes.

Susan Stefan: That's great because I have 10 minutes to go.

Continuity, especially with regard to healthcare records, is important. I have a friend who provides great care. I can't imagine he ever didn't provide great care. But his system was sued. He said, it's not an issue that the EHR can communicate to three different systems, is it? And I said, yes, it is.

This Texas appellate case is a road map of what not to do. A family nurse practitioner sees a 14-year-old and diagnosis her with depressive disorder after she says she has suicidal thoughts. She doesn't do psychiatric workup, no questionnaires, but she prescribes Celexa with no refills. The prescription is changed, and three refills are allowed, which is more than the state allows.

The record is altered post-litigation to say, "patient is told to come back for a follow-up visit in 30 Days." You guys know, you can't alter digital records. The date of the altered record was entered

into the lawsuit.

In July, she got the refill and overdosed and died on Benadryl, which wasn't even the Celexa. The person in charge of the office was the person most found guilty by the jury. Even though it was lower-level staff that broke the law repeatedly.

Recognize and reward people who excel at working with people with mental health disabilities. I have implored hospitals to recognize staff who are skilled at this. One hospital recognized that a female janitor had really good skills with the psych patients and they paid for her to go to nursing skill. She loves this place now, and she's able to use her skills to work a better-paying job. It's a win-win-win.

If you have an EMTALA issue, if you have outside evaluators doing psych evals, make sure they're practicing according to the scope of the state and your hospital.

Now, making changes in a resistant organization. Some of you may know the story of anesthesia. It was practiced on animals from vets well before the effects of it were known. It was used by dentists after that.

In London, using anesthesia was called "the Yankee dodge." "Most of the things that were considered strengths, like strength of speed, were suddenly not valued anymore." A doctor was driven to suicide because of the stigma around the use of anesthesia. Another doctor was thrown into a mental hospital, where he died two weeks later.

So, cultural changes to institutions, not for the change of heart. But, there are things you can do for the betterment of your patients. Can you reduce the number of involuntary hospitalizations? I would advise to not do this alone. You will be marginalized and ill-treated, and the chances of success go way down. So, find allies within and outside of your organization. That's really important. I've been doing this work for almost 45 years, and I could not have done it without people supporting the work that I did. That's one of the reasons I'm trying to support JASPR. We need to support each other in making improvements.

What happens when the treatment team disagrees? It's important to document differences of opinion. Again, you may get pushback for that. But if you're signing your name on something, if you're part of professional team, you need to document, including differences of opinion.

Finally, I know a lot of people that do this work are exhausted. It may be because you're working too much. But really, I've worked 16-hour days and have been fired up, charged up because I'm seeing changes made and people's lives getting saved. Exhaustion and burnout are not from working hard. It's from feeling lonely, frustrated, and discouraged. It may feel like you're treading water. Doing work that has meaning is, for the most part, very energizing. I thank you for being on this call. I hope we're all allies in this work we do. And I'm open for questions. I'm happy to take

questions.

Kelly Koerner: That's great. For those of you who need to hop off, we are recording and we'll send that out afterwards. We'll also send out resources Susan has been talking about.

First question: can you talk more about a safety plan, and what you might say?

Susan Stefan: What works for you? What will deescalate for you? My safety plan will look different than Kelly's. It's very individualized to that person's needs and their drivers for suicidality.

A safety contract is when a therapist says, "you've got to promise me you won't kill yourself." The patient and professional doesn't get much out of that. How do you enforce it? Case law has made that point. Basically, it's seen as, in retrospect, a failure to incorrectly assess that person's risk. "Just promise you won't kill yourself and we're all copacetic." That's not the be-all and end-all of treatment. A safety contract is not enough. A safety plan, or a crisis plan, is a more detailed and individualized look at what you can do in the future, should you start feeling the triggers of suicidality.

Kelly Koerner: That's great. Another question that came up has to do with red-flag gun laws. What are those and what aren't those? And in particular when you see someone with a cognitive impairment? Anything you want to say about those intersections between gun safety and people with cognitive impairments.

Susan Stefan: Red flag laws vary from state to state. In some states, mental health professionals can utilize them, and in others, they can't. In some states, they're framed in a stigmatizing way. Generally, the mental health community is all for these laws if they're written in a neutral way. We think it's extremely helpful for people who are victims of domestic violence. They permit due process, which means the person can go to court and get their guns back.

But, for the most part, framed neutrally and broadly, red-flag laws tend to be good. If you give me your state, we can email later. I can look up the law for your state and I can tell you whether you have the power to utilize it. If you're going to use it, you need to know what the standard is. Different states have different standards around imminence and danger. I think those laws are way less emotionally traumatizing to people and way more keyed into a good result than involuntary hospitalization. I'm glad to expand on that if we know the person's state.

Kelly Koerner: That's a great transition to our wrap-up. We'll send out the recording and the resources that Susan has mentioned. Susan, you've generously mentioned you'd like to follow up on people's questions. If you want, we'll send out an email for people to send their follow-up questions to. Susan, as you can, you can reply.

Susan Stefan: I'm glad to do it. Thank you for having me. And thank you, Liz, who is the real-time

captioner.

Kelly Koerner: Thank you Susan. Thank you all for joining. Signing off now. Bye bye.

[End of event.]