Legal and Liability
Issues in Suicide Care

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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...

- 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

Create a leadership-driven, safety oriented culture

Suicide Care Management Plan
- Identify and assess risk
- Use effective, evidence-based care
- Provide continuous contact and support

Develop a competent, confident, and caring workforce

CONTINUOUS

APPROACH

QUALITY

IMPROVEMENT
Contact

Zero Suicide
Suicide Prevention Resource Center
Education Development Center
zerosuicide@edc.org
202-572-5361
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

Skip Simpson

Lanny Berman

Susan Stefan
Presenter

Skip Simpson, J.D.
Zero Suicide: Fear not-just do it
Definition of Liability

- 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?

- 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

- 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

- 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

- “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

- 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

- 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

“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.”

Hospitalization

- Hospitalizing patients who talk about suicide compared to less restrictive care – what are potential legal implications?

Professional Judgment

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

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.
Audience:

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

Lanny Berman, Ph.D., ABPP, PLLC
Lessons Learned from the Courtroom: An Expert’s Perspective
Suicide Bereaved Attitudes toward Therapists*

- 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...

- 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...

- 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

- 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

- 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

- 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?

**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
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)

**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)

- 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

- 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

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

<table>
<thead>
<tr>
<th>Appleby et al., 1999</th>
<th>Busch et al., 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barraclough et al., 1974</td>
<td>(78%)</td>
</tr>
<tr>
<td>Chavan et al., 2008</td>
<td>Isometsä et al., 1995</td>
</tr>
<tr>
<td>DeLong &amp; Robins, 1961</td>
<td>(78%)</td>
</tr>
<tr>
<td>Hall et al., 1999</td>
<td>Karch et al., 2011</td>
</tr>
<tr>
<td>Hiemeland, 1996</td>
<td>(NVDRS: 71%)</td>
</tr>
<tr>
<td>McKelvey et al., 1998</td>
<td>Smith et al., 2013</td>
</tr>
<tr>
<td></td>
<td>(73% of depressed VA patients)</td>
</tr>
<tr>
<td></td>
<td>Berman (in preparation)</td>
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<td></td>
<td>(57%)</td>
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</table>
Reasons for Denial of Suicide Ideation

- 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)

- 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

- **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

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

(Berman, in preparation)
A Comment on the C-SSRS*

- 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

- 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

• 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)

- 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

- 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

• Update staff training
  • AMSR (www.sprc.org) – knowledge competencies
  • RRSR (www.suicidology.org) – behavioral competencies
Acknowledgement

• 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

Audience:

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Presenter

Susan Stefan
Zero Suicide and the Law
Zero Suicide ≠ More Restrictions

- Zero Suicide ≠ More Hospitalizations
- Zero Suicide ≠ 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

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

- Medical malpractice
- Civil commitment
- Competence
- Informed consent
- Advance directives/health care proxies
Difficult or impossible to establish liability for outpatient suicide (Delaware 2015; Mississippi 2014)


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)
Nevertheless, some generalizations are possible

- 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:

- Inpatient facilities/systems
- Inpatient professionals
- Outpatient professionals
Inpatient facilities/systems

- Look around!
- Most hospital suicides are hangings
- Between 75-84% of hospital suicides involve environmental hazards
- Pay special attention to patients’ rooms and bathrooms
Inpatient facilities/systems (continued)

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

- 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

- 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

- 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

- 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?

- 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

- 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

- 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.
Suggested Readings


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


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. 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 forward to Other:
   □ responsibility to children □ belief system □ Looking 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)
8. Makes progress resolving the crisis
9. Can look back on successfully handling a similar crisis in the past
10. Engages constructively with treatment staff
11. Shows interest in non-inpatient treatment
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
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
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
   Support Network
36. CNS trauma, signs, symptoms such as cognitive loss of executive function
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

Photocopy Form Page 1 04/11
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
   □ 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 (13) and a tendency to experience involuntary stays as particularly traumatic. (12)

54. □ Chronic self-destructive potential is not responding to hospitalization. Acceptance of risk is the price of outpatient treatment. (9, 10)

55. □ Hospitalization might worsen a problem with dependency

56. □ Contingent suicidality: Patients who threaten suicide if discharged are typically not high risk (9)

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,

Evaluator - Print Name ___________________________ Signature ___________________________ Date _______ Time _______
References:


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

Brief Documentation of Release and Mitigation of Risk (Reference/Comment Page) Photocopy Form # 10/10
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—or 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.