



Rx FOR RISK
IS A PRMS
PUBLICATION

2015 | Volume 23 | Issue 3

Rx FOR RISK

Addressing risk management issues and concerns in the field of psychiatry

Treatment of the Suicidal Patient: Part II

Given the importance of this topic and feedback received from our readers, we have decided to offer Treatment of the Suicidal Patient: Part II.



Reading Rx for Risk on a screen?

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Letter to the Editor

Thanks to PRMS for the thoughtful issue on suicide and its risk management aspects before and after. I wanted to comment on one point that was not addressed in the issue.

The articles address extensively and in detail what the psychiatrist should be aware of at intake or during treatment and what considerations apply after a completed suicide. However, the current pattern of practice often does not have the psychiatrist involved until late in the game. Initial intakes and screenings in today's climate may be made by psychiatric nurses, clinical nurse specialists, physician extenders, social workers and even by Master's level counselors, some of whom may continue to be involved in providing psychotherapeutic services over extended periods. It is not uncommon for the psychiatrist to be allowed very short opportunities to assess the patient and to be relegated to a purely prescribing role. While many might see this situation as appalling, it is current.

May I respectfully suggest that this practice landscape be addressed in a future issue, together with information on the relevant concerns in that context.

Thank you.

Thomas G. Gutheil, MD

Possible reading:

Gutheil, T.G.: Risk management at the margins: less familiar topics in psychiatric malpractice. *Harvard Rev Psychiatry* 2:214-221, 1994. Discusses, inter alia, shared treatment situations.

Editor's Response

We thank Dr. Gutheil for pointing out that our recent newsletter on suicide did not address split treatment. We are addressing that in this issue, also devoted to treating patients with suicidal behaviors, by including an updated version of our split treatment article that was originally published in the *Psychiatric Practice & Managed Care Newsletter* (May/June 1999 issue). We appreciate the feedback!



SUICIDE LAWSUIT DATA

We thought it might be of interest if we shared our data from The Psychiatrists' Program on resolution of lawsuits against our insured psychiatrists involving a patient suicide or suicide attempt. Here is data from our closed suicide cases, 2009-2014:

Manner of suicide or suicide attempt (top 5):

- Hanging – 50%
- Gunshot – 14%
- Overdose – 9%
- Jumping – 5%
- Carbon monoxide – 5%

Location of suicide or suicide attempt:

- Outside of practice or facility – 61%
- Inpatient (hospital) – 22%
- Correctional (jail or prison) – 13%
- Residential treatment facility – 4%

Resolution of lawsuit:

- Settled before trial – 41%
- Dismissed – 40%
- Summary judgment or motion to dismiss – 10%
- Defense verdict – 6%
- Suit abandoned – 2%
- Settled during trial – 1%

IN THE HEADLINES

Sadly campus suicides and the increased need for mental health services at colleges and universities continue to make the news. Here are a few recent articles of note:

- » [Scelfo, J. "Suicide on Campus and the Pressure of Perfection," New York Times, July 27, 2015](#)
- » [Friedman, RA. "Teenagers, Medication and Suicide," New York Times, August 3, 2015](#)
- » [Schwarz, A. "More College Freshmen Report Having Felt Depressed," New York Times, February 5, 2015](#)
- » ["Anxious Students Strain College Mental Health Centers," well.blogs.nytimes.com, May 28, 2015](#)



Suicide Risk Assessment is Addressed in the APA's Newly Released 3rd Edition of

GUIDELINES FOR THE PSYCHIATRIC EVALUATION OF ADULTS

The American Psychiatric Association (APA) has recently released the third edition of the APA Practice Guidelines for the Psychiatric Evaluation of Adults (2015). A copy of the guidelines in their entirety can be downloaded for free at <http://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426760>. While not creating the standard of care in and of themselves, such authoritative clinical guidelines can be used as a factor indicating the appropriate standard of care in any patient care situation. Accordingly, we recommend that you review and become familiar with the guidelines.

The Guidelines Include Current Guidelines for Assessing Suicide Risk

The guidelines are also noteworthy for including current guidelines for suicide risk assessment. The entire document is 170 pages long and roughly 15 of them relate to suicide risk assessment (pages 18-23, 57-64, and 139-140). This is relevant in light of the fact that the APA's guidelines on treating patients with suicidal behaviors are more than five years old and therefore cannot be assumed to be current.

In these guidelines, the APA has made the following four statements in regard to suicide risk assessment and subsequently elaborated upon them:

- » There are 13 bullet points comprising relevant factors the physician should assess during the initial psychiatric evaluation of a patient.
- » In addition to those factors, there are 6 additional factors to assess during the initial evaluation if the patient reports current suicidal ideas.
- » For patients who have made prior suicide attempts, the physician should evaluate the details of those attempts.
- » Finally, the fourth statement addresses the physician's estimation of the patient's suicide risk.

The APA identifies several ways in which a physician can go about obtaining information from the patient. Once this information is obtained, the guidelines advise the physician to undertake individualized evaluations, noting several strategies for tailoring the evaluation to the specific patient (e.g., take note of stressors). The APA also recommends open-ended questions and advises to take into account certain conditions about the patient (e.g., intellectual disabilities).

The APA recognizes that suicide risk assessment is mostly compromised of the physician's judgment and analysis of the information he obtained through patient evaluation. Guidance is provided for weighing the factors to estimate the risk.

Finally, physicians must take into account the unique balance each patient has between their own motivations for suicide and the reasons they have for living. Once the physician has taken all of the relevant previously mentioned factors into account, he can make an attempt to estimate a person's overall suicide risk and make recommendations based upon his findings.



RISK MANAGEMENT CHECKLIST: POST PATIENT SUICIDE

Managing Risk after a Patient Suicide/Suicide Attempt

Preliminary Things To Do

- » Call PRMS (800-245-3333) to report an event.
- » Do not change (alter) the record.
- » Do not discuss the case – call your Claims Examiner first (800-245-3333).

Mitigate Your Risk

- » Talk with your Claims Examiner.
- » Determine the status of the patient's bill (do you want a bill to go to the patient's family?)
- » Ensure proper record management.
 - If the record is paper, lock it up.
 - Protect the integrity of the record.
 - Keep correspondence with insurance company and attorney separate from clinical record.
 - Get guidance prior to releasing information.
- » Understand that confidentiality survives the patient's death.
- » Obtain guidance from your Claims Examiner in processing requests for information, such as from:
 - Family members
 - Medical examiners
 - Insurance companies
 - Other treating providers
 - Facilities
- » Obtain guidance from your Claims Examiner prior to participating in reviews:
 - Peer review
 - Incident review
 - QA review
- » Be prepared to deal with your own emotions.
 - Remember that not all adverse events are the result of medical errors.
 - Remember that not all medical errors result in a claim or lawsuit.



- » Be prepared to deal with the patient’s family.
 - Your interaction with the family should be driven by the family and will depend on the amount of interaction you had with the family during the patient’s treatment.
 - Family members, including spouses, may not always have the right to access confidential treatment information (unless appointed to represent the estate).
 - An appreciation of confidentiality obligations need not prevent you from offering support and expressing care and concern for the patient’s family. You can also inform them of appropriate resources and/or recommend and refer family members for counseling or treatment – all without disclosing confidential patient information.
 - If you chose to send a condolence card, consider sending a pre-printed card without adding more than your signature.
 - Only consider attending the patient’s funeral if invited by the family. Be prepared to answer the question of how you know the deceased without breaching confidentiality.

THE PSYCHIATRISTS’ PROGRAM[®] CAUSE OF LOSS (2005-2014)

PRIMARY ALLEGATION	ALL AGES	ADULTS	MINORS
Incorrect Treatment	38%	39%	36%
Medication Issues	17%	17%	16%
Suicide/Attempted Suicide	16%	16%	16%
Incorrect Diagnosis	7%	7%	9%
Other	7%	7%	5%
Unnecessary Commitment	4%	4%	2%
Breach of Confidentiality	3%	3%	3%
Improper Supervision	3%	2%	8%
Vicarious Liability	2%	2%	2%
Forensic	1%	1%	1%
Duty to Warn / Protect	1%	1%	2%
Abandonment	<1%	<1%	-
Boundary Violation	<1%	<1%	-

Notes: “Primary allegation” is the main allegation by plaintiffs’ attorneys of what the psychiatrist did wrong. | “Incorrect treatment” will represent a high percentage of cases because plaintiffs’ attorneys often use a broad, general allegation initially; this category includes all types of cases, including suicide and psychopharmacology. | The category labeled “Improper Supervision” refers to supervision of patients as well as of other providers.



SPLIT TREATMENT & THE SUICIDAL PATIENT

Shared Treatment/Shared Risk

Whereas once it was the psychiatrist who alone provided both therapy and medication management, today split treatment arrangements, where a psychiatrist provides medication management and a non-medical therapist provides psychotherapy, have become the norm. In such arrangements, psychiatrists frequently find that they have substantially less control over their patients' overall treatment than they did in more traditional arrangements. As a result, they have become increasingly aware of, and increasingly concerned about, the potential for malpractice exposure related to such relationships.

What impact does the existence of a split treatment relationship have on the psychiatrist's duty to the patient? None. The psychiatrist always remains responsible for ensuring that the patient receives the appropriate care. A physician's duty to provide the standard of care emanates from the common law and from professional, ethical, and statutory/licensing responsibilities. What changes is that the psychiatrist can be held liable for the acts of other professionals involved in the care of patients.

Defining Collaborative Relationships

The American Psychiatric Association's "Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Non-medical Therapists," (www.apa.org), defines traditional relationships between psychiatrists and non-medical therapists. In "Guidelines for Prescribing Psychiatrists in Consultative, Collaborative, and Supervisory Relationships," Sederer et al. also defined these relationships and developed corresponding guidelines, specifically for prescribing psychiatrists.

Shared treatment relationships, due to their potential complexities and varied natures, may not always fit into only one of these specifically defined categories, but the definitions are important tools for both psychiatrists and non-medical therapists to use in understanding and communicating with each other and the patient about the nature and scope of the shared treatment relationship.

The definitions provide guidance for the professionals and their patients in understanding the parameters of responsibility for each person in the patient - multiple provider relationship. Clarifying the relative responsibilities and expectations, as well as ongoing communication among the parties, is critical for successful split treatment that meets the standard of care and reduces liability risks.

In a malpractice lawsuit, these definitions may be used to assist in understanding the relative duties and responsibilities in a shared treatment relationship. Ultimately, however, the court and the jury will decide about the actions and/or omissions of the psychiatrist and non-medical therapist that will be determinative of liability. They may choose to ignore the distinctions on which the professionals functioned. Legislatures and licensing bodies have long recognized the independence of other healthcare professionals with regard to their responsibilities for patient care but unfortunately, the legal system is slow to catch up.



Carefully Considered Collaboration

Of course the greatest concern in the treatment of the suicidal patient is ensuring the patient's safety and thus the first step is determining whether split treatment is appropriate for a particular patient. Is it better that you, yourself provide the patient's therapy and necessary medications or is it preferable that the patient have a separate therapist and that you provide medication management? This may be determined in part by the availability of qualified therapists in your local area with whom you feel comfortable sharing the responsibility for a high-risk patient. Unfortunately, it may also be determined by the patient's insurance carrier. Psychiatrists often face conflicting responsibilities between determining what care a patient needs and, at the same time, complying with the cost containment requirements of the patient's insurance company. Split treatment may in fact be the only option for certain patients.

Depending upon a particular patient's diagnosis and level of stability, this approach to treatment may require a minimum of communication between the two providers. When dealing with the suicidal patient, however, a different level of collaboration and vigilance is necessary both to ensure patient safety and to mitigate possible malpractice exposure on the part of the psychiatrist. Thus while it might be possible to work in a split treatment relationship with a less than ideal treatment partner when dealing with a patient with very mild symptoms, with a suicidal patient, it is imperative that the psychiatrist and the therapist be able to function as a team.

Psychiatrists who have been in practice for a number of years may already have a cadre of therapists with whom they are comfortable sharing treatment. Other times, the patient will choose a therapist the psychiatrist does not have a professional relationship with – as is often the case with early career psychiatrists. Before agreeing to work with a therapist in a split treatment arrangement, psychiatrists should seek answers to the following questions.

- » **Who is this person and what are her qualifications?** Is the therapist someone who is known in the community? Do you have colleagues who have worked with her? Remember, not only are you dealing with patient safety issues, you are dealing with your own personal liability exposure so it is important that you assure yourself that the therapist is up to the task of dealing with a complex patient. Find out the level of her training. How many years has she been practicing? What is her experience? Is she licensed? Does she have malpractice insurance? Some of this information may be available on the therapist's practice website or a "find a therapist" site such as Psychology Today. If this is not available, ask the therapist herself. To lessen the awkwardness you might offer your information as a way of introducing yourself to the therapist and suggest that she provide the same to you.
- » **How often does she plan on seeing the patient?** Does she have coverage for when she is not available? Can she be reached in an emergency?
- » **How will the two of you communicate?** In person? By telephone? Via email? (if the latter remember that email messages should be made part of the patient's chart.) How often will you be in contact? What information will be shared? Aside from the agreed upon routine contact, will there be certain events/situations that will trigger contact for example, missed appointments, medication changes, reports of suicidal gestures, loss of protective factors?



- » **Have you discussed and agreed upon your respective roles?** While each will take the lead in their agreed upon role, you must be careful to avoid intransigence and not operate within rigid parameters. For example, if the therapist notes a negative change in the patient's behavior following a medication change she should be prepared to bring this to your attention.
- » **Is there a mutual understanding of the patient's current status?** Are there signs that each should watch for that would indicate a deterioration?
- » **How will you handle potential conflicts?** It is not uncommon for manipulative patients to try to pit clinicians against one and other by presenting vastly different information to each thus causing the clinicians to recommend courses of treatment that may be conflicting.
- » **What is your gut telling you?** What is the temperament of the therapist? Managing a suicidal patient requires a great deal of energy. Do you feel the therapist is up to the challenge?

It may be helpful to memorialize your understanding of the treatment arrangement in a formal written agreement. It may also be beneficial to have the patient be a party to this agreement so that he understands what information will be shared, whom to reach out to and how, and to otherwise manage expectations. (See *Rx for Risk*, Volume 23, Issue 2, 2015.)

A Split in Split Treatment

For the successful management of the suicidal patient, it is important that there is a meeting of the minds and clear understanding of respective roles. As the patient will likely be seeing the provider giving therapy on a more frequent basis, he or she may develop a closer bond with them than the psychiatrist whom they see less frequently for medication management. It is not unheard of for therapists to have their own ideas regarding medication which they share with the patient and which may or may not be in accordance with the recommendations of the psychiatrist.

If a psychiatrist finds himself in a situation where his recommendations are being ignored by the patient and are not supported by the therapist, he should consider the feasibility of remaining in the treatment relationship. While it may be the psychiatrist's clinical judgment that the patient would benefit from medication, he must consider whether another psychiatrist might have greater success in convincing the patient of this and whether his continued involvement in the treatment relationship does anything further than increase his liability exposure.

Other Areas of Exposure

Heretofore we have discussed split treatment in situations where the psychiatrist and therapist are providing care at different locations and practicing independently. Another common occurrence, however, is split treatment within the same medical practice or clinic. This may be a large group practice that employs both psychiatrists and non-medical therapists or it might be a county mental health clinic with one psychiatrist working as an independent contractor alongside a group of non-medical therapists. In these settings, should a claim arise due to the actions or inactions of a therapist, the psychiatrist working with that therapist can expect to be brought into the action under one of two theories of negligence.



Vicarious Liability/Respondeat Superior. Vicarious liability is based upon the legal doctrine of respondeat superior, which literally means “let the master respond.” Provided that the therapist was found to have committed the act of negligence within the scope of his or her employment (i.e., engaging in an act to further the business of the psychiatrist) the psychiatrist may also be found liable. This can occur even though the psychiatrist’s own care of the patient or supervision of therapist was beyond reproach.

Negligent Supervision. Should an error occur on the part of the therapist, the plaintiff will undoubtedly look at whether there were any lapses in oversight to support an allegation of negligent supervision. Psychiatrists who work in settings where they are required to sign off on the treatment plans of patients whom they do not personally see may fall under this category even if they do not in reality have supervisory authority over the therapist.

Conclusion

The elements for increased liability risk are present in split treatment relationships, but each individual situation must be evaluated to understand its particular risk profile. The risk analysis must evaluate the risks inherent in the treatment of the particular patient (What are this patient’s clinical needs?), coupled with an evaluation of the risks presented by the shared relationship (How does the split treatment complicate/increase problems in meeting the standard of care for this patient? Are there ways to manage those risks so that you are satisfied that patient care needs are being met?).

Risk management seeks to improve the quality of care provided to patients and to reduce legal liability. The best risk management strategy is to pursue quality care that is in the patient’s interest. Coordination and communication with non-medical therapists are essential to providing good treatment.

For Further Reading

Gutheil, T.G.: Risk management at the margins: less familiar topics in psychiatric malpractice. *Harvard Rev Psychiatry* 2:214-221, 1994

Simon, I.S., Hales, R.E. *Textbook of Suicide Assessment and Management*, American Psychiatric Publishing, Inc. 2006

Sederer, L.I., Ellison, J. Keyes, C. Guidelines for prescribing psychiatrists in consultative, collaborative, and supervisory relationships. *Psychiatric Services*, September 1998 Vol 49. No. 9

Guidelines for psychiatrists in consultative, supervisory or collaborative relationships with nonphysician clinicians, American Psychiatric Association Resource Document 2009

Have any comments or questions about an article?

We would love to hear from you!

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