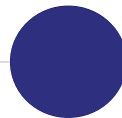
RISK MANAGEMENT WHEN TREATING PATIENTS WITH SUICIDAL BEHAVIORS



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More on Medical Marijuana

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143 articles

As discussed in my prior post, Why Marijuana is Still a "High" Risk for Physicians, some people believe that enforcement guidance memos issued by the Department of Justice (DOJ) allow for medical marijuana use if such use is allowed under state law. The most often cited DOJ memo on this issue is the "Cole Memo" from 2011, specifying that federal resources

important barrier not mentioned is the restrictions on prescribing controlled substances.

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I HAVE NO RELEVANT FINANCIAL RELATIONSHIPS WITH COMMERCIAL INTERESTS.

DISCLAIMERS

- PRMS funded the initial distribution of the SAFE-T cards to residency programs years ago.

- Nothing I say today is legal advice.

OBJECTIVES

- Explain the importance of documentation of initial and ongoing suicide assessments
- Assess and document suicidal risk initially and at critical junctures in treatment
- Document the decision-making process when assessing and treating patients at risk for suicide or violence
- Recognize online activity and its impact on patients

ELEMENTS OF A MALPRACTICE LAWSUIT

1) **Duty of Care**
   The psychiatrist owed a duty of care to the patient (to meet the standard of care)

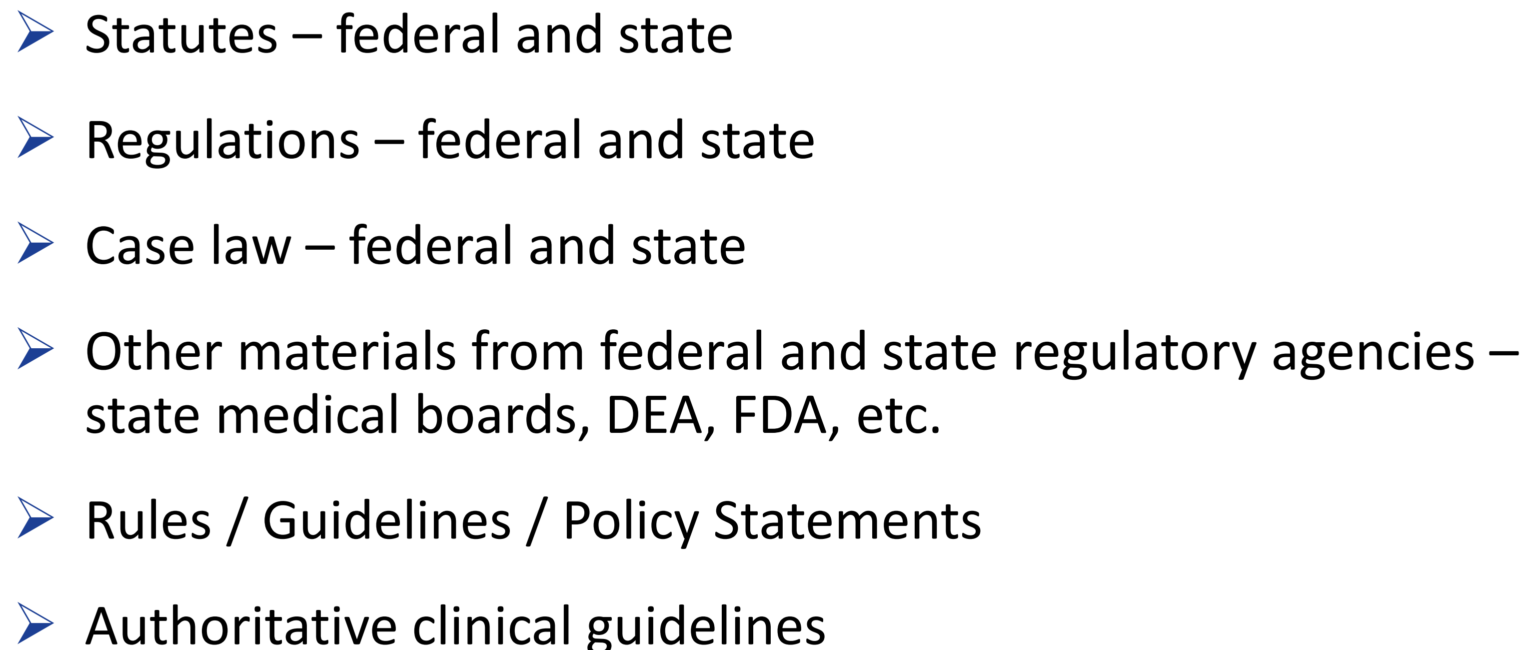
2) **Breach of Duty**
   The psychiatrist was negligent (the care provided fell below the standard of care)

3) **Damages**
   The patient suffered an adverse outcome (injury)

4) **Causation**
   The patient’s damages were a direct result of the psychiatrist's negligence

DETERMINING THE APPLICABLE STANDARD OF CARE

Many items may be admissible, along with expert testimony, to determine the issue of standard of care. The following items could be relied upon as ***evidence of*** the appropriate standard of care:



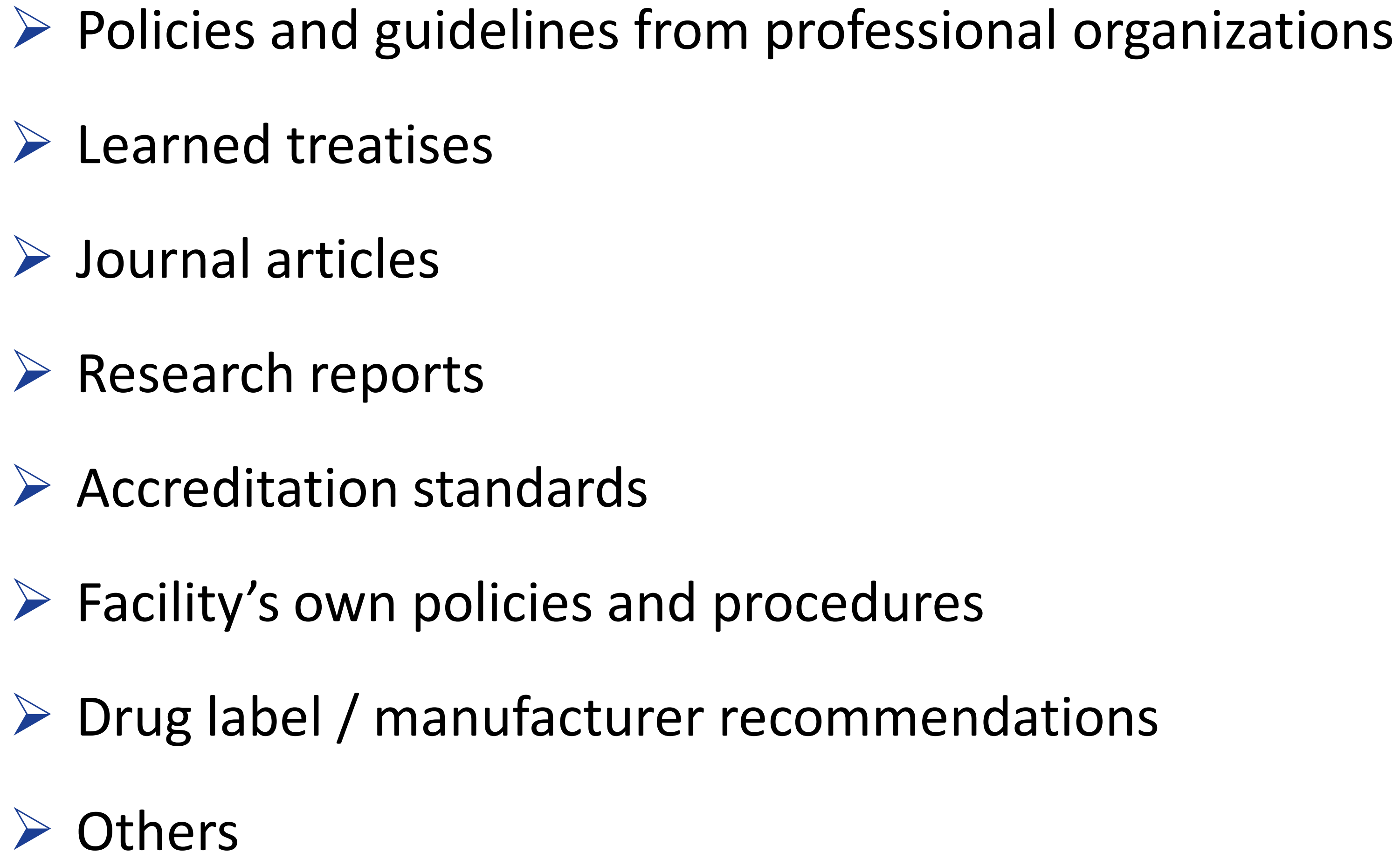
- Statutes – federal and state
- Regulations – federal and state
- Case law – federal and state
- Other materials from federal and state regulatory agencies – state medical boards, DEA, FDA, etc.
- Rules / Guidelines / Policy Statements
- Authoritative clinical guidelines

CASE LAW

- “The science of psychiatry represents the penultimate grey area. Numerous cases underscore the inability of psychiatric experts to predict, with any degree of precision, an individual’s propensity to do violence to himself or others”
- “Indeed, psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession”

(Paddock v. Chacko, 1988)

DETERMINING THE APPLICABLE STANDARD OF CARE



THE PURPOSE OF ASSESSING DANGEROUSNESS

"To determine whether an individual poses a risk of endangering self or others now or in the near future and to identify what interventions are necessary to minimize that risk."

(Phillips, 2012)

ASSESSING RISK

- No one can predict future dangerous behavior with absolute certainty
- Approaches to risk assessment:
  - **Actuarial**
    - Uses information derived from group data instead of an individualized assessment of dangerousness
  - **Clinical**
    - Individualized assessment based solely on psychiatrists' intuition, experience, and clinical orientation
  - **Structural clinical judgment (preferred)**
    - Psychiatrist uses a list of empirically validated risk factors known to be associated with violence
    - Psychiatrist uses clinical judgment to weigh importance of risk factors

(Phillips, 2012)

ASSESSING RISK

- You have to ask about access to firearms
  - APA Guidelines: because of the increased risk, mental health providers should routinely ask patients about suicidal thoughts, intents, or plans, including this question:
    - “Do you have any guns or weapons available to you?”
  - “Evidence indicates that the presence of firearms in the home is a risk factor for suicide”
  - “Miller and Hemmenway suggested that the availability of firearms increases the risk of suicide for three reasons:
    - Many suicidal acts are impulsive
    - Many suicide crises are self-limiting
    - And guns are common in the US and lethal
  - They contend ‘restriction of access to lethal means is one of the few suicide prevention policies with proven effectiveness’”

(Cook et al, 2012)

PATIENTS AT RISK FOR SUICIDE

Cannot predict suicide

but

risk of suicide may be foreseeable

STANDARD OF CARE – SUICIDE CASES

* Suicide risk is identified and treated appropriately *

Standard of care factors:

- Whether there was adequate identification and evaluation of suicide risk indicators and protective factors for the patient with suicidal behaviors
- Whether a reasonable treatment plan was developed based on the assessment of the patient's clinical needs
- Whether the treatment plan was appropriately implemented and modified based on an ongoing assessment of the patient's clinical status
- Whether the provider was professionally current regarding the assessment and treatment of patients with suicidal behaviors
- Whether documentation was adequate to support that appropriate care was provided in terms of the assessment, treatment, and ongoing monitoring of the patient

How to minimize liability risk associated with treating patient with suicidal behavior

Utilize three risk management strategies to provide good clinical care

- Strategy #1: **COLLECTING INFORMATION**
  - Past treatment records
  - Assessments
  - Stay professionally current
- Strategy #2: **COMMUNICATING**
  - With patient
  - With others
- Strategy #3: **CAREFULLY DOCUMENTING**
  - Assessments
  - Decision-making process

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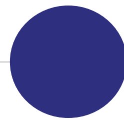
RISK MANAGEMENT STRATEGY #1

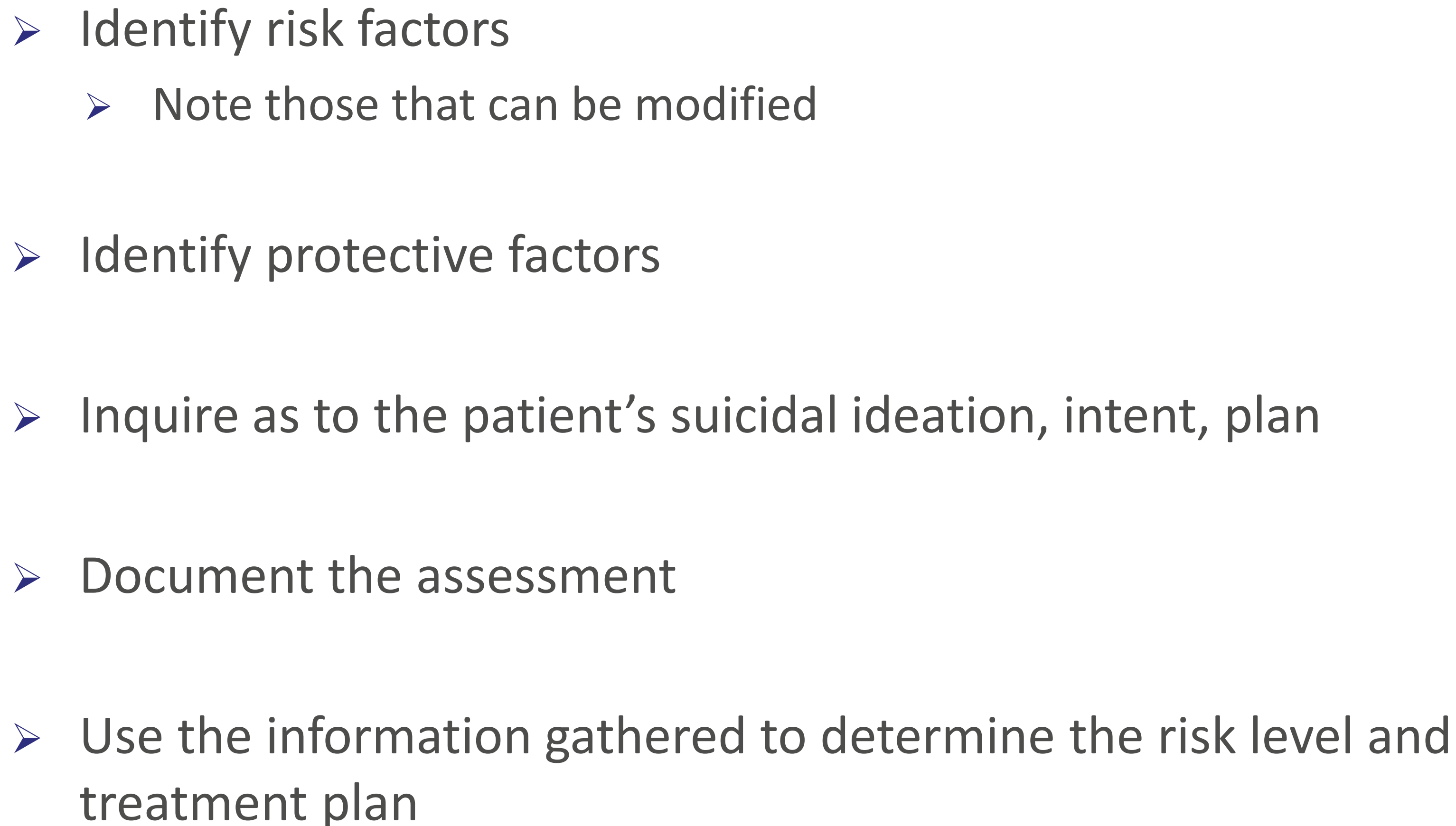


Collecting Information

COLLECTING INFORMATION *ABOUT THE PATIENT*

- Assess patients at significant points in treatment
- Assessment is ongoing
  - Consider the possibility of comorbid conditions
    - Substance use
    - Medical conditions
- Try to get prior records; if can't, document attempts
- Obtain collateral information from family and significant others
- Inquire about access to weapons
- Consistently utilize specific, reputable suicide assessment and treatment methodology/resource

CRITICAL COMPONENTS – SUICIDE RISK ASSESSMENT



- Identify risk factors
  - Note those that can be modified
- Identify protective factors
- Inquire as to the patient’s suicidal ideation, intent, plan
- Document the assessment
- Use the information gathered to determine the risk level and treatment plan

APA PRACTICE GUIDELINES FOR THE PSYCHIATRIC EVALUATION OF ADULTS

ASSESSMENT OF SUICIDE RISK

Statement 1: contents of initial psychiatric evaluation

Statement 2: contents to include if current suicidal ideas are reported

Statement 3: contents to include if prior suicide attempts are reported

Statement 4: document estimation of patient's suicide risk

(APA, 2016)

COMMON PITFALLS – SUICIDE RISK ASSESSMENT

- No assessment
- Delegating risk assessment
- Documenting assessment
- “Gut” assessments
- Risk assessment forms
- “No harm contract”

COMMON PITFALLS – SUICIDE RISK ASSESSMENT

- Assuming self report is accurate
- Using black and white thinking

(Nau, 2014)

COLLECTING INFORMATION *ABOUT THE PATIENT*

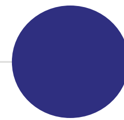
Consider what patients in the digital age can do:

- Use social networking – Facebook, chat rooms, blogs
- Watch YouTube
- Become addicted to pornography online
- Post sexually suggestive content online
- Sexting
- Be online targets for sex
- Bully online
- Be bullied online
- Gamble online
- Online gaming – can be very violent
- Search online for information about dangerous behaviors

COLLECTING INFORMATION
STAYING PROFESSIONALLY CURRENT

- Know the criteria for involuntary hospitalization
- Be familiar with reputable treatment guidelines
  - Document reasons for deviating

RISK MANAGEMENT STRATEGY #2



Communicating

COMMUNICATING

- Do not rely solely on "no harm contracts"
  - No legal force
  - But … may be one part of a comprehensive treatment plan
- Consider discussing patient internet activities
- Risk reduction planning should be completed with patient involved
- Educate patient on services available

COMMUNICATING

- Communicate with other healthcare professionals
  - Do not hesitate to seek consultation or second opinion
  - Other treating providers, covering providers

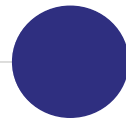
- Communicate with family and significant others
  - Involve and educate
  - Stress responsibility
  - Access to weapons

COMMUNICATING

- Remember: patient safety is *exception* to confidentiality

- Consider alerting family members / significant others to risk of suicide without patient authorization when:
  - The risk is significant
  - They do not seem to be aware of the risk
  - They might contribute to patient's safety

RISK MANAGEMENT STRATEGY #3



Carefully Documenting

DOCUMENTING

APA Practice Guideline for the Treatment of Patients With Suicidal Behaviors.

From Part A (v); Table 9- General Risk Management and Documentation Considerations in the Assessment and Management of Patients at Risk of Suicide

… Careful and attentive documentation, including:

- Risk assessments
- Record of decision-making processes
- Descriptions of changes in treatment
- Record of communications with other clinicians
- Record of telephone calls from patients or family members
- Prescription log or copies of actual prescriptions
- Medical records of previous treatment, if available, particularly treatment related to past suicide attempts

DOCUMENTING

Critical junctures for documentation:

- At first psychiatric assessment or admission
- With occurrence of any suicidal behavior or ideation
- Whenever there is any noteworthy clinical change
- For inpatients, before increasing privileges or giving passes and before discharge

DOCUMENTING

Sample suicide risk assessment note

- Suicide risk factors identified and weighed (low, moderate, high)
    - *Identify modifiable factors*
- Protective factors identified and weighed (low, moderate, high)
- Overall assessment rated (low, moderate, high, or range)
- Treatment and management intervention informed by the assessment
- Effectiveness of interventions evaluated

(Simon and Hales, 2006)

Risk Factors

- Psychiatric Disorder(s): Axis I and Axis II____
  ____
- Key Clinical Considerations____
  e.g. Intense psychological pain/anguish, agitation, anxiety/panic, physical pain, anhedonia, impulsivity, hopelessness, command hallucinations, worthlessness, intense self-loathing, excessive guilt, feeling that death would bring relief, executive functioning deficits, relationship difficulties, status of important connections
- Suicidal Behavior____
  e.g. History of prior attempts, self-injurious behaviors, attempts in hospital, writing/talking/ruminating about death
- Family History/Psychopathology____
  e.g. History of suicidality and major mental illness, abuse and neglect
- Precipitants/Stressors____
  Triggering events, e.g. loss of or threat of loss of relationship, recent deaths, medical illness, public/social humiliation, exposure to trauma, legal or financial difficulties
- Access to Firearms/Other Lethal Means____

Protective Factors

- Internal____
  e.g. Ability to cope with stress, religious beliefs, frustration tolerance, a sense of hope
- External____
  e.g. Responsibility to children/pets, social supports-specifically positive connections, therapeutic relationships

Suicide Inquiry

- Ideation____
  e.g. Frequency, intensity, duration – recent, worst ever
- Plan____
  e.g. Timing, location, lethality, availability, preparation

DOCUMENTATION & PROFESSIONAL JUDGMENT – GENERAL PRINCIPLES

- Do not let attorneys and their experts make up their own story about your treatment
  - Document your decision-making
- A physician who chooses one therapeutic approach from a number of reasonable approaches should not be held liable solely because it appears after-the-fact that a different reasonable approach might have been more beneficial
- Courts defer to the treating physician – as long as there is something to base that deference on
  - Contemporaneous documentation of treatment

TAKE AWAY POINTS

- Psychiatrists are not responsible for perfectly predicting patient behavior when working with violent and potentially violent patients

- Psychiatrists are expected to meet the standard of care

- The best risk management strategy = good clinical judgment
  - Weight the pros and cons, then choose what you believe is the best course of action

QUESTIONS?