



GUIDELINES FOR

Prescribing Psychiatrists

IN CONSULTATIVE, COLLABORATIVE, OR
SUPERVISORY RELATIONSHIPS

Created: 1995
Revised: 1999, 2002
Reviewed: 2014

crico

Introduction

As part of patient care activities, most prescribing psychiatrists enter into a variety of professional relationships with other clinicians. When division of responsibility in these relationships is ambiguous, quality of treatment may be affected. Quality of care can be improved by delineating responsibilities and clarifying expectations between providers regarding communication, documentation, coverage arrangements, sharing of confidential information, and handling of emergencies.

A task force of CRICO has considered these issues and developed guidelines for prescribing psychiatrists working with other caregivers. These guidelines offer a structure for approaching consultative, collaborative, and supervisory relationships. These guidelines will not apply in all circumstances, nor will all elements of the guidelines pertain in every situation.

In the course of working with other caregivers, a psychiatrist may develop concerns about the quality or safety of the treatment another clinician is delivering. *In our view, the patient's care and well-being are the primary obligations of every physician.* When a psychiatrist believes that the appropriateness or quality of treatment is questionable, he/she should take action commensurate with the level of concern for the patient's safety. Often a forthright discussion with the other clinician will resolve the matter. For more complicated situations, a psychiatrist may wish to review the matter with an independent colleague or contact a risk management consultant for advice.

The task force recognizes that "consultation," "collaboration," and "supervision" convey different, sometimes overlapping, meanings to health professionals. We offer the following definitions toward a common understanding of the terms.

Definitions

Consultation

Consultation occurs between two professionals who are both licensed or credentialed to provide patient care. One (the ‘consultee’) requests an opinion from the other (the ‘consultant’). The consultee considers the recommendations of the consultant and decides whether or not to follow them, based on his/her more extensive knowledge of the patient.

A consultation can be “formal” or “informal.” A formal consultation is usually based upon a review of the patient’s record and/or a meeting with the patient. In a formal consultation, the consultee usually includes the consultant’s recommendations in the patient’s medical record. By contrast, when performing an informal consultation, the consultant rarely learns the patient’s identity, reviews the medical record or engages in direct contact with the patient. A consultee should obtain permission from an informal consultant before recording his/ her name in the medical record.

As an independent healthcare professional, the consultant determines the appropriate scope of his/ her examination of the patient; this may differ from what the consultee requested. The consultant’s documentation should be consistent with the consultation provided.

Because this definition of “consultation” assumes the consultee has sufficient professional training and knowledge to evaluate and implement, or not implement, medical recommendations made by the consultant, prescribing psychiatrists are discouraged from considering their interactions with unlicensed clinicians to be “consultations.” A psychiatrist asked by an unlicensed clinician for pharmacotherapy consultation should recommend that the patient be referred for full, formal psychiatric evaluation.

EXAMPLES

Informal Consultation: At a conference on mood regulating agents, a psychiatrist sought out the lecturer following her presentation and asked for advice about the treatment of a patient whose renal disease made treatment with lithium

salts problematic. Although the patient’s identity and thorough history were not discussed, sufficient information was conveyed about the patient to establish which medication might be safer and potentially effective. The consultant’s suggestions were implemented but her name was not recorded in the patient’s medical record.

Formal Consultation: A psychiatrist sought consultation from a colleague with expertise in the treatment of refractory psychotic disorders. The consultant obtained sufficient information from the referring psychiatrist to focus the consultation request, then interviewed the patient and offered suggestions for further treatment. The consultant’s recommendations were documented in a letter sent to the referring psychiatrist and incorporated into the consultee’s medical record for that patient. The referring psychiatrist implemented those suggestions he felt to be most salient to the patient’s care.

Collaboration

Collaboration occurs when two licensed or credentialed professionals share ongoing responsibility for complementary aspects of a patient’s treatment (sometimes referred to as “co-treatment” or “dual treatment”). This relationship differs from “consultation” in that each clinician is independently responsible for the application of particular skills in the direct care of the patient. The delineation of responsibilities should be determined by the collaborators and then discussed with the patient in order to clarify roles and to obtain the patient’s consent to this arrangement.

Collaboration is often initiated by a request for an “evaluation” or “consultation.” For example, a licensed psychologist providing psychotherapy may ask a psychiatrist to determine whether pharmacotherapy might help a particular patient. If the psychiatrist’s evaluation suggests pharmacotherapy is appropriate and acceptable, the psychiatrist might begin a collaborative relationship with the psychotherapist in the care of that patient, or offer referral to another clinician who could provide pharmacotherapy collaboratively.

This task force cautions psychiatrists about prescribing medications at the request of clinicians who are unlicensed and uncredentialed; this type of interaction is not a collaboration according to the proposed definition. A psychiatrist prescribing medications at the request of an unlicensed/ uncredentialed clinician may expose him/herself to bearing the predominance of the clinical and ethical liability. Unlicensed or uncredentialed clinicians may not have met professional or regulatory standards and may not carry malpractice insurance (see example below). (Note: In some milieu programs or HMO staff models, collaborative relationships exist between psychiatrists and credentialed, but unlicensed, clinicians.)

EXAMPLES

Collaboration with Licensed Clinicians: A licensed psychologist sought consultation from a psychiatrist regarding the advisability of medicating his patient's anxiety. The psychiatrist discussed the patient with the psychologist, met with the patient, reviewed relevant medical records, and diagnosed panic disorder. The psychiatrist then offered to prescribe anti-panic medication to the patient in collaboration with the psychologist. The patient agreed to add pharmacotherapy to the ongoing psychotherapy and the clinicians discussed delineation of responsibilities for the patient's care.

Responding to Requests from Unlicensed Clinicians: An unlicensed therapist contacted a private practice psychiatrist to refer a patient for evaluation and treatment. The psychiatrist requested some preliminary information about the patient and also asked about the therapist's background/ credentials. The psychiatrist indicated to the therapist that she would accept this as a referral for evaluation and treatment, but could not enter into a collaborative relationship with the therapist. The psychiatrist asked the therapist to have the patient call to set up the appointment. As a result of the evaluation, the psychiatrist diagnosed major depression and started the patient on antidepressant medication. The patient chose to discuss his diagnosis and treatment with the therapist. A report of the patient's evaluation and treatment was not sent to the therapist; however, at the patient's request, the psychiatrist discussed the patient's condition and treatment plan with the therapist as she had with the patient's spouse.

Supervision

Supervision, for the purpose of this guideline, is a mandated relationship between two professionals in which one (the 'supervisee') is generally obliged to follow the recommendations of the other (the 'supervisor') over a period of time. The supervisor is expected to evaluate the competence of the supervisee, taking into consideration his/her background, training, and experience, and to confer responsibility on the supervisee accordingly (Hilliard J. Personal communication, 1996). A supervisor may exercise guidance or control of the supervisee's work directly or through a designee (a colleague with acknowledged expertise in the relevant practice area who has explicitly agreed to accept supervisory responsibility). Not all educational and didactic activities constitute supervision; however this committee suggests that this supervision guideline may be useful in some didactic relationships.

Supervision may be intensive (occurring at frequent intervals and with close attention to the patient and treatment) or infrequent, as well as focused or general. The parameters will depend on the supervisor's assessment of and degree of confidence in the supervisee's ability to practice independently. The supervision may change over time as the supervisee becomes more experienced and competent.

Supervision may be part of formal professional training, as in a psychiatric residency program, or it may be imposed through other mechanisms. Massachusetts General Laws Chapters 94C and 112 §§ 80E–G, for example, require that the prescribing practices of a Registered Nurse Psychiatric Clinician (RNPC) be supervised by a psychiatrist. The Massachusetts Board of Registration in Medicine may condition the licensing of an impaired physician on supervision by another physician. Or a health care entity may impose supervision on a clinician as a remedial action to improve the quality of care being delivered to its patients.

When supervision is voluntarily sought, the parameters of the relationship are less stringent; e.g., the supervisee is not formally required to follow the supervisor's suggestions or to undergo assessment of competence by the supervisor. A psychiatrist who infrequently prescribes medication, for example, might ask another psychiatrist to 'supervise' the treatment of a patient with a complicated medication regimen. The requesting physician would write all medication orders or prescriptions but would

also seek advice to enhance treatment or prevent complications. This common interaction may best be considered an educational activity. If the supervisor (the person providing the ongoing education) comes to believe that the educational service is becoming a consultative arrangement, s/he should follow the consultation guidelines noted above.

EXAMPLES

Resident Supervision: The director of an inpatient unit was expected to supervise the psychiatric residents' clinical work on that unit. The residents were expected to inform all their patients of the supervisory relationship and to review the management of each case with their supervisor. The supervisor's approach emphasized the development of the residents' skills, allowing them considerable freedom in their treatment choices. If the supervisor questioned the appropriateness of a treatment decision, however, she would actively review the decision with the resident and consider whether it was appropriate for her to insist on a different approach or to meet with the patient for a reassessment in order to assure proper patient care.

Supervision of a Registered Nurse Psychiatric

Clinician: A Registered Nurse credentialed as a Psychiatric Clinician (RNPC) arranged for a qualified psychiatrist to take on the role of Supervising Physician (SP). Together, they wrote practice guidelines in accordance with Massachusetts law and the regulations of the Board of Registration in Medicine, the Board of Registration in Nursing, and the Department of Public Health. Two to four times per month, the nurse met with and paid the psychiatrist an hourly fee to review a minimum of 20% of her prescriptions. The nurse documented supervisory input in a log and, when appropriate, in patients' medical records.

The psychiatrist documented a review of supervision at least every three months and discussed the review with the RNPC. All patients receiving prescribed medications from the RNPC were informed of the presence and role of the supervisor. The psychiatrist recognized responsibility for providing ongoing supervision as necessary to assure that the RNPC had appropriate guidance. Patients whose needs exceeded the defined scope of the RNPC's practice were referred to the SP or elsewhere as appropriate.

Imposed Supervision: The Board of Registration in Medicine, acting on a complaint from a patient who claimed to have been improperly prescribed an addictive substance, determined that a psychiatrist suffered from depression and narcotic use disorder that interfered with the quality of his psychiatric practice. After a period of intensive treatment, one condition for his return to work was that he receive clinical supervision on his treatment of all substance-abusing or substance-dependent patients. He met with a supervising psychiatrist weekly, and documented the supervisor's advice in his patients' records. The supervisor, experienced in work with impaired physicians and with addiction treatment, recognized both a responsibility to oversee the appropriateness of treatment and offer guidance as needed. There was the additional responsibility to inform a monitoring agency of the supervisee's continued attendance at supervision.

The chart which follows provides prescribing psychiatrists with a framework and guidelines for consultation, collaboration, and supervision for prescribing psychiatrists.

Assess the Context and Circumstances

	CONSULTATION	COLLABORATION	SUPERVISION
Communicate with the Other Clinician(s)	Informal consultation may not include all elements listed in this column.		These responsibilities may be assigned to the super-visor, as appropriate.
1. Determine who else is clinically involved in the patient's care.			
2. Determine why have you been asked to assist.			
3. Discuss your treatment styles and goals. If a provider's treatment of a patient appears to be problematic, discuss your concerns with that clinician, particularly addressing any issues involving the safety of the patient or others.	Treatment styles: When consulting to a PCP, e.g., assess the PCP's experience and comfort with psychiatric illness and prescribing psychiatric medications.		
4. Define your respective roles.	Roles: Generally, in a <i>consultation</i> you are asked to give an opinion which the consultee is free to follow or not, based on his/ her knowledge of the patient.	Roles: In a <i>collaboration</i> you deliver direct care to the patient concurrent with other licensed or credentialed mental health or healthcare professionals.	Roles: <i>Supervision</i> is a formal arrangement in which you train and evaluate another mental health professional. Some kinds of voluntary, educational arrangements are referred to as "supervision;" if this type of arrangement begins to become more consultative, consider following the consultation guidelines.
	When working with a resident as a consultant, collaborator, or supervisor, consider inviting the resident to attend or participate in your evaluation of the patient if this would be an appropriate teaching exercise and if the patient consents.		
5. Clarify communication expectations among providers. Address content, frequency, and preferred methods of communication.	Communication: If you are asked to consult or collaborate with a clinician who is being supervised: <ul style="list-style-type: none"> Ask that clinician to inform his/ her supervisor about your participation in the assessment or care of the patient. An RNPC should inform his/her supervising physician, a resident should inform his/ her direct supervisor, and Determine whether you will communicate with the clinician, the supervisor, or both. 		
6. Establish a communication plan for emergencies.			

Assess the Context and Circumstances (continued)

	CONSULTATION	COLLABORATION	SUPERVISION
Communicate with the Patient	Informal consultation may not include all elements listed in this column.		These responsibilities may be assigned to the super-visor, as appropriate.
1. Determine the patient’s understanding of each mental health care provider’s role.			
2. Discuss the patient’s preferences regarding disclosure of information.			
3. Confidentiality: Explain to the patient the clinicians’ plan for sharing relevant information among themselves and with the patient. Address any conflicts between the patient’s and clinicians’ preferences for sharing information.	<p><i>Patient Confidentiality, Conveying Information Among Clinicians:</i></p> <p>a. When working with another clinician as a consultant, collaborator, or supervisor:</p> <ul style="list-style-type: none"> ▪ Ask for the patient’s consent to divulge and discuss any mental health information with the other clinician. ▪ If, after discussion, the patient does not permit you to discuss relevant clinical material with another treating clinician, inform the clinician that information exists which the patient will not permit you to share. Do not divulge sensitive material without the patient’s consent. Continuation of treatment with a patient who does not permit open communication of medically necessary information among treating clinicians may not be clinically responsible or feasible. <p>b. This committee recommends disclosing most supervisory relationships to patients. For example, residents and RNPCs should remember to inform patients about the involvement of their program supervisors and supervising physicians.</p>		
4. Confidentiality: convey limits to confidentiality, including disclosures for insurance/reimbursement purposes and disclosures in situations involving risk of harm to the patient or others.			

Assess the Context and Circumstances (continued)

	CONSULTATION	COLLABORATION	SUPERVISION
Evaluate Resources			
1. Inquire about insurance, financial resources, and other economic considerations that could influence treatment decisions.			
2. Assess the availability and appropriateness of family or significant others in assisting in treatment implementation (e.g., aiding medication compliance, monitoring patient safety, providing financial assistance).			
3. Among providers, clarify arrangements for fees and billing.			

Address the Issues

	CONSULTATION	COLLABORATION	SUPERVISION
Address the Clinical Issues	A particular consultation, collaboration, or supervision may include some but not all of these elements.		
1. Formulate a psychiatric diagnosis based on: <ul style="list-style-type: none"> a. relevant clinical history, examination, treatment experience, and/or b. diagnostic test results (e.g., laboratory studies, neuropsychological tests, imaging), and/or c. contributing medical, psychological and social problems. 			
2. Identify the clinical issue(s) requiring immediate attention.			
3. Assess for transference or countertransference issues that might be influencing the request for a medication consultation.			
4. Recommend further steps, as appropriate, including: <ul style="list-style-type: none"> a. additional diagnostic interviews or tests, and/or b. pharmacotherapy (addressing relevant drug interactions), and/or c. psychotherapy (e.g., individual, group or family), and/or d. other support (e.g., vocational, entitlement enrollment, rehabilitation, self-help or recovery programs) 			

Address the Issues (continued)

	CONSULTATION	COLLABORATION	SUPERVISION
5. Clarify responsibilities for treatment and follow-up among health care providers.			
6. If you will provide treatment, discuss risks and benefits with the patient, and obtain informed consent, as appropriate.			
Address the Supervisory Issues			<ol style="list-style-type: none"> 1. Assess the supervisee's diagnostic and treatment skills, including the ability to: <ol style="list-style-type: none"> a. understand diagnostic procedures and results (e.g., imaging, laboratory studies, neuropsychological tests), and/or b. develop a biopsychosocial formulation (including transference and countertransference issues), and/or c. identify key issues requiring immediate attention, and/or d. understand available medications and the role of pharmacotherapy in treatment. 2. Assess the supervisee's understanding of roles and responsibilities, including: <ol style="list-style-type: none"> a. the role of the supervising or prescribing psychiatrist, b. when to contact the supervising or prescribing psychiatrist. 3. Develop and revise a supervisory plan as necessary which addresses the learning needs of the supervisee.

Follow Through

	CONSULTATION	COLLABORATION	SUPERVISION
Fulfill Agreements to Communicate			
1. Communicate assessments and treatment plans to the patient and other clinicians, as previously agreed.			
2. Communicate relevant information to other authorized recipients as agreed upon in the discussion of patient confidentiality (e.g., family, payer, licensing board, training program).			
Plan Next Steps			
1. Discuss possible follow up.			
2. Consider discussing the procedure to be followed if either the patient or a provider wants to redefine (or terminate) the treatment relationship.			

Bibliography

American Psychiatric Association: Guidelines for psychiatrists in consultative, supervisory, or collaborative relationships with nonmedical therapists. *American Journal of Psychiatry*. 1990;13:1489–91.

Appelbaum PS: General guidelines for psychiatrists who prescribe medication for patients treated by nonmedical psychotherapists. *Hospital and Community Psychiatry*. 1991;42:281–82.

Benarroche CL, Astrachan BM: Interprofessional role relationships. In Talbott JA, Kaplan SR, eds. *Psychiatric Administration*. New York, NY. Grune & Stratton, 1993.

Ellison JM, Gold IM, Osser DN: Practical implementation of the psychiatric nurse clinical specialist/ psychiatrist collaboration: Risk management aspects. Wellesley, MA. Massachusetts Psychiatric Society, 1996.

Ellison JM, Smith JM: Intertherapist conflict in combined treatment. In Ellison JM, ed. *The Psychotherapist's Guide to Pharmacotherapy*. Chicago, IL. Year Book Medical Publishers, 1989.

Goldberg RS, Riba M, Tasman A: Psychiatrists' attitudes toward prescribing medication for patients treated by nonmedical psychotherapists. *Hospital and Community Psychiatry*. 1991;42:276–80.

Hansen-Grant S, Riba M: Contact between psychotherapists and psychiatric residents who provide medication backup. *Psychiatric Services*. 1995;46:74–77.

Harper G: Focal inpatient treatment planning. *Journal of the American Academy of Child and Adolescent Psychiatry*. 1989;28(1):31–37.

Manian FA, Janssen DA: Curbside consultations: A closer look at a common practice. *Journal of the American Medical Association*. 1996;275:145–47.

Pilette WL: The rise of three-party treatment relationships. *Psychotherapy*. 1988;25:420–23.

Primm S, et al: Fundamentals of combined treatment. In Ellison JM, ed. *The Psychotherapist's Guide to Pharmacotherapy*. Chicago, IL. Year Book Medical Publishers, 1989.

Riba M, Goldberg RS, Tasman A: Medication backup in psychiatry residency programs. *Academic Psychiatry*. 1993;17:32–35.

Sederer, LI: The four questions. In Sederer LI, Rothschild AJ, eds. *Acute Care Psychiatry: Diagnosis and Treatment*. Baltimore, MD. Williams & Wilkins, 1997.

Woodward B, Duckworth GS, Gutheil TG: The pharmacotherapist-psychotherapist collaboration. In Oldham JM, Riba MG, Tasman A, eds. *Review of Psychiatry* Vol. 12. Washington, DC. American Psychiatric Press, 1994.

COMMITTEE

Lloyd I. Sederer, MD, Co-Chair
McLean Hospital

James Ellison, MD, MPH, Co-Chair
Harvard Pilgrim Health Care

MaryAnne Badaracco, MD
Beth Israel Deaconess Medical Center

George Dominiak, MD
Mt. Auburn Hospital

William Falk, MD
Massachusetts General Hospital

Gordon Harper, MD
Children's Hospital

Burt Johnson, MD
Harvard Community Health Care

Catherine Keyes, JD
CRICO

Nancy Nitenson, MD
Spaulding Rehabilitation Hospital

David Osser, MD
Taunton State Hospital

Randall Paulsen, MD
Beth Israel Deaconess Medical Center

Peter Reich, MD
MIT Health Services

Andrew Stoll, MD
Brigham & Women's Hospital

Gail Tsimprea, PhD
McLean Hospital

PROJECT SUPPORT: CRICO

Alison Anderson

Jock Hoffman

For more information contact CRICO.

crico | Protecting Providers.
Promoting Safety.

1325 Boylston Street • Boston, MA 02215
617.450.5500 • www.rmhf.harvard.edu