Promises, Promises: Don't Rely on Patients' No-Suicide/No-Violence "Contracts"

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Case 1

The patient was referred to the mental health center by his primary care physician as an "emergency," depressed, with lots of vegetative signs, and requesting medication. He had thought of suicide, but denied an active plan. He said he had been seeing a psychiatrist, but refused to sign an authorization for information release. Based on that refusal, the clinicians at the center did not call his current psychiatrist or the referring general practitioner for more information.

They did a pretty thorough interview, documenting the patient's severe depression, marked feelings of betrayal and abandonment, intense paranoia about doctors and other people, and refusal to talk much about his psychiatric history (except to criticize his doctors). In the end, the center psychiatrist refilled his prescriptions (based on what he said he had been taking), added an additional drug, and, like the crisis counselor before him that afternoon, exacted a promise from him that he would not hurt himself or anyone else. He was to return in a few days.

The next day, the patient killed his primary care physician, his girlfriend, and himself.

We could discuss the above vignette in terms of the clinic staff's failure to contact the other clinicians (the psychiatrist and the primary care doctor), both of whom would have given information about his potential dangerousness to himself and others. However, I harped on that in a previous column. The point I want to discuss this month is whether or not patients' no-suicide (and no-violence) "contracts" are reliable.

Somebody must have written a book praising such contracts, because they are very common in psychotherapy and inpatient practice. I have no quarrel with their utility in a *therapeutic* context, as a means of conveying concern, fostering a patient's participation in his or her care, or encouraging positive behavior *[Editor's note: see Goin's column in the July, 1998 issue of this journal for a more detailed discussion of these issues]*. But clinicians should not, in my opinion, use them to assuage their concerns about real danger.

Every few weeks or so I review a suicide (or, less commonly, a homicide or combination) in which, at some point a few days or weeks before, the patient signed a contract or "promised" not to hurt himself or others. This was often done in the context of discharge discussions after just a few days of inpatient care.

Case 2

A young mother of a 4-month-old infant was admitted to the hospital with severe depression and morbid, disorganized suicidal thoughts. She had been moderately depressed for a week or two after the birth, never really got better, and recently developed signs of a major depressive episode. "Close monitoring" was ordered, as well as a sleeping medication and an antidepressant. The next day, the patient reported that she felt better and was wondering whether or not she should be in the hospital. She had gotten her first good night's sleep in weeks, ate a good breakfast, and said her one dose of antidepressant must be working already. Her psychiatrist suggested that she stay a day or two longer, until the therapeutic team could review her case.

The next day, things still appeared to be going well. Several chart notes documented her apparent lack of suicidal ideation (and her embarrassment at having had suicidal plans in the first place). She said she appreciated the chance for a rest in the hospital, but now she needed to be at home with her baby. An MMPI that day showed mild depression and no psychosis. Notes from a treatment team meeting suggest that the staff commiserated with her comments that she had been overwhelmed by the trials of motherhood, and believed she was now reintegrated and just needed some education and support to help her at home. Her suicide precautions were discontinued just before discharge, which occurred less than 3 days after admission. The very last entry in

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the nurses' progress notes was "patient contracts to call if she feels suicidal." The patient killed herself a week later, several days before her first follow-up appointment.

At the malpractice trial, during cross examination of the doctor, the plaintiff's attorney focused on the fact that the admission documents reflected very serious symptoms and it didn't make sense that she was "cured in 3 days." He noted that she had gone from suicide precautions to discharge in less than a day, with no preliminary passes or immediate post-discharge follow-up. When the doctor brought up the no-suicide contract, the attorney said "She wasn't thinking about that so-called 'contract' when she felt like her whole life was over, and she was in great mental pain, and she wasn't thinking straight, was she, doctor?" The doctor could only say "I don't know."

Truly serious suicidal or homicidal impulses—at least those related to mental illness—must be very strong to overcome our internal and external prohibitions against self-destruction and inappropriate violence. Although there are exceptions (and some readers are no doubt using the exceptions to argue with my *general* point at this very moment), patients in the throes of those impulses are unlikely to check them because of some promise, written or not. We accept the fact that seriously ill patients are often unreliable when considering other patient promises and behaviors, such as those related to taking medications as prescribed. It makes sense to view no-suicide/no-violence promises in the same way.

Decisions to discharge a patient, issue an off-unit pass, or reduce one's level of monitoring require both clinical expertise and reliable information. These include our training and experience in interviewing, knowing how and when to seek other sources of history and ancillary information, recognizing signs of psychopathology and risk in the interview and ancillary information, weighing those signs and risks against issues of patient benefit and rights, understanding when it is appropriate to allow the patient to make his or her own decision about protection (e.g., hospitalization), and considering involuntary measures.

Case 3

A doctor with no prior history of psychiatric care was arrested for prescribing unnecessary narcotics to undercover officers, then released on bond. That evening, he was hospitalized after an almost-lethal overdose. When seen on the medicine service, after several hours in intensive care, he said the overdose had been "silly ... just an impulse" and he was anxious to leave the hospital. He refused voluntary psychiatric hospitalization, saying it would only make things worse and humiliate him in the small city in which he practiced. His wife was also against hospitalization, saying he was "just fine ... this is a family matter."

In spite of the patient/doctor's fervent promises to notify his wife and call the psychiatrist if any suicidal thoughts came to mind, the consultant believed discharge would be dangerous and began involuntary hospitalization proceedings. The commitment was contested, and the patient's lawyer cited the fact that the hospital record didn't document any obvious signs of depression after the overdose. Nevertheless, a judge ordered 2 weeks of initial psychiatric hospitalization and evaluation. The lawyer succeeded in getting the location shifted from the patient's home community to a private facility some distance away, to avoid the stigma of local treatment or state hospitalization.

When the 2 weeks had passed, the patient once again protested his confinement, said the whole matter had been a mistake, and made it clear that he was perfectly capable of recognizing his own symptoms and calling for help if necessary. This time he was successful in getting discharged, and killed himself the day after he was released.

Sometimes, of course, the patient wants to leave and the psychiatrist, after appropriate consideration, doesn't believe he is "committable." Although detention criteria vary from state to state, *not being "committable" is not the same as being ready for discharge (or not needing hospitalization)*. The clinician is expected to review the patient's needs and try to get the patient to accept inpatient care or other treatment and precautions if they are clinically indicated. If you can't convince the patient, so be it. Do what you can, document your efforts and contingency plans, and move on.

Case 4

Often, however, well-presented alternatives will make sense to the patient, and support the part of him or her that wants to live, not die.

A 62-year-old man with a lifelong history of relapsing and remitting major depression requested discharge from a partial hospitalization program. He had been admitted several weeks before with severe depression and suicidal thoughts, but had steadily improved. The staff planned to discharge him in about a week, and he had named a particular day that would be convenient. Follow-up would be scheduled, but might be a little difficult since he lived on a farm; the psychiatrist came to a nearby town only once a week. The patient was felt to be

pretty reliable, and the staff planned to have him sign their routine no-suicide contract.

When a visiting psychiatrist, unfamiliar with the patient, reviewed the plan with the treatment team, they were able to provide a great deal of information about the patient's history and present condition. They reported that his moods were sometimes up or down, but that he appeared much better than he had on admission. He had been to an aunt's funeral a few days before but seemed to be doing well. He seemed to be adapting to the intrathoracic defibrillator he had received a few months before. They reported a family history of depression, including a sister's suicide a few years before, and noted that a brother had a debilitating illness. The patient had been divorced after 30 years of marriage, and the family farm was now for sale as part of the settlement. Further review indicated that the first anniversary of the divorce would fall on the day after he was to be discharged.

At interview, the patient appeared mildly depressed, with occasional smiles. He spoke without much emotion about leaving the program, and it soon became clear that he had little to do with his time (especially considering his recent cardiac disability). Although his parents had both lived to be very old, he did not expect to do the same. When asked about the divorce, he expressed some emotion, briefly becoming tearful, but then saying "It's probably for the best." The farm, about to be sold, had been in his family for several generations. He said once again, "It's probably for the best . . . my daughter has a room for me at her house." He still felt guilty about his sister's suicide, many years before, believing he might have prevented it. The brother with the debilitating illness had become terminal and was expected to die within a couple of weeks.

After discussing these substantial losses and signs of risk, the treatment team agreed that the patient should not be discharged as planned and began exploring alternatives such as an extended stay or a "step-down" plan. The patient was amenable to the recommendation, and seemed to appreciate their support.

The take-home lesson this month: Don't rely solely on a patient's statement that he or she is not—or is no longer—suicidal or dangerous. If a promise or contract were sufficient, we'd be unnecessary (and we need the work).