

Law and Psychiatry

Contracting For Safety *Redux*

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It's hard to believe it's been six years since I wrote the last column about so-called "contracts for safety" (also called "no-harm" or "no-self-harm" contracts or agreements).¹ Some people didn't get the message. In fact, *lots* of people seem not to have gotten it. Here's the message:

Don't rely on them.

What could be clearer than that? The rest of this column will explain the reasons for such a harsh view of something that may superficially seem a good idea. My clinical and forensic experience, the relevant psychiatric and nursing literature, and the standard of care (to which you should practice to provide adequate care and avoid liability) all indicate otherwise.²⁻⁶ For brevity, I will refer to such a contract as a CFS, whether singular or plural.

A caregiver's most important focus should be clinical—evaluation, treatment, and protection of the patient. Sometimes, however, important points made outside the clinical setting capture one's attention. Here's part of a deposition from a malpractice lawsuit in which a doctor and a psychiatric hospital were accused of negligently allowing a suicidal patient to leave the unit unescorted. It doesn't tell the whole story, of course, but the medical record suggested that the CFS (here called a "no-harm contract") was a significant factor in the patient's being given unsupervised grounds privileges, during which he killed himself.

Attorney for plaintiff: Knowing that Mr. Smith had attempted suicide 3 days earlier and had described hearing voices telling him to kill himself, did you assess his suicide risk before you ordered unsupervised grounds privileges?

Psychiatrist (defendant): Yes.

Attorney: Please tell us what you did to assess and decrease that risk.

Psychiatrist: I reviewed the chart. I asked the nurses if he still had suicidal thoughts and I asked him if he was still thinking about killing himself.

Attorney: What did you find when you reviewed the chart before you ordered the grounds pass?

Psychiatrist: That he had talked about hurting himself the day before, but he signed a no-self-harm contract

the morning that I wrote the grounds pass order.

Attorney: A "no-self-harm contract." What does that mean?

Psychiatrist: It's a promise not to commit suicide and to tell somebody if you're thinking of it.

Attorney: O.K. And does that work? Does it keep patients from killing themselves?

Psychiatrist: In my experience, yes. I trust my patients.

Attorney: You trust all of your patients?

Psychiatrist: Well, you can pretty much tell which ones to trust. And the nurses discuss the no-self-harm contract with them ahead of time.

Attorney: Have you ever had a patient kill himself after signing one of these contracts?

Psychiatrist: No. Except for Mr. Smith.

Attorney: Have you ever had *any* patient kill himself or herself at all?

Psychiatrist: No. This is the first one. That I know of.

Attorney: And this one happens to have signed a no-self-harm contract just a few hours before he committed suicide?

Psychiatrist: Well, yes.

Attorney: So, technically speaking, I guess, all of your patients who have killed themselves had signed one of these no-harm contracts?

Psychiatrist: I don't think that's a fair sample. I already said I've only had one suicide. Who knows how many were prevented because of the contract?

Attorney: I understand that Mr. Smith alone doesn't make a scientific study, but we're here because he's the one who died, tragically... You're right; my question may not have been entirely fair to you... You say you trust your patients to keep the no-self-harm promise. Or contract. Why is that?

Psychiatrist: Why do I trust them? I have no reason not to. They have no reason to lie to me or to the nurse who

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got the contract signed.

Attorney: Let's talk about that "no reason," and maybe the word "lie," for a minute, doctor. The patient wanted a grounds pass, right? Might that be a reason to lie, well maybe not to lie but to sign the paper, to get what he wants? A grounds pass?

Psychiatrist: I guess so.

Attorney: And he might have, just speaking hypothetically, he might have wanted the grounds pass so he'd be able to get away from the unit and kill himself. Is that possible, doctor?

Psychiatrist: Anything's possible.

Attorney: Well, isn't that exactly what happened in Mr. Smith's case, doctor?

Psychiatrist: I don't know that he was trying to trick us. I don't know what he on his mind when he signed the contract.

Attorney: And that's my point. Thank you, doctor. Would you agree that, since you don't know what was in his mind, it is dangerous to rely on that contract when you make decisions to remove supervision and let him go outside without an escort?

Psychiatrist: I already said anything's possible. But we have to trust the patient sometime.

Attorney: We'll get to the "sometime" in a minute. You would also agree, wouldn't you, doctor, that, in this case, whatever trust you placed in the patient or the contract failed to prevent Mr. Smith's suicide?

Psychiatrist: I agree he killed himself. I guess so.

Attorney: Let's go on to some other reasons that a patient might, or might not, keep his contract not to kill himself. Would you agree with me that lots of patients who don't want to kill themselves when they sign your no-harm contract change their minds, whether it's an hour later or the next day?

Psychiatrist: Sure. You can't predict suicide, you can only try to prevent it.

Attorney: O.K. And when they change their minds, do they always tell someone, like a nurse?

Psychiatrist: Not always.

Attorney: Well, is it *common* that they don't tell anyone?

Psychiatrist: I guess so. It's hard to predict.

Attorney: So in that particular scenario, the contract wouldn't prevent suicide, right?

Psychiatrist: I guess it might not.

Attorney: That isn't something we have to guess at, is it? If they change their mind and want to commit suicide and they don't tell anyone, then the contract hasn't done what you hoped it would, right?

Psychiatrist: Right.

Attorney: How about this scenario: A lot of patients who

are in the hospital for wanting to kill themselves have trouble controlling their behavior, right?

Psychiatrist: Right.

Attorney: I mean, if they could control their impulses, their impulses to kill themselves, they probably wouldn't need you, or at least you wouldn't need to put them into the hospital, does that make sense?

Psychiatrist: Right.

Attorney: Does it also make sense that if they can't control their impulse to kill themselves, then making a promise or signing a piece of paper isn't likely to magically cure them—strike that—isn't likely to give them the will power or motivation or change their lives and problems or whatever so they all of a sudden *can* control the impulse?

Psychiatrist: It doesn't cure. It's not designed to cure their illness, just to make them stop and think about what they're doing and think about their promise.

Attorney: Well, these patients have *trouble* stopping and thinking when it comes to their impulses to kill themselves, or take pills, or shoot themselves, don't they?

Psychiatrist: Yes.

Attorney: A lot of trouble, or they wouldn't be in the hospital, right?

Psychiatrist: I guess... Right.

Attorney: And that trouble controlling impulses could be from being really depressed, or being psychotic, or being intoxicated, or not thinking straight for some other reason, right?

Psychiatrist: Right.

Attorney: And you wouldn't expect such a patient to keep a promise they might not even know they made, right?

Psychiatrist: Well, he'd usually know he made it.

Attorney: My point is—strike that. So from what you've said, doctor, you'd agree that it is likely to be unreasonable to rely on a no-harm contract to protect a patient who has threatened to commit suicide?

Psychiatrist: It might be. Depends on the patient.

Attorney: Well, for some patients it would be unreasonable?

Psychiatrist: For some, yes.

Attorney: What kind of patients?

Psychiatrist: Well, sort of what you said. Patients who are having trouble with reality or who are so depressed they have trouble seeing a reason to stay alive or controlling their impulses.

Attorney: And Mr. Smith. Had he had trouble controlling his impulses a couple of days before the staff had him sign the no-harm contract?

Psychiatrist: When he picked up the gun and cocked it? That was 3 days before. Yes. I mean, he didn't pull the

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trigger that time.

Attorney: And the admission assessment that you signed 2 days before he died said you were worried about his self-destructive impulses at that time?

Psychiatrist: Yes.

Attorney: And Mr. Smith had a history of hearing voices that told him to shoot himself the day he was admitted, and one of the nurses, nurse Brown I think, wrote in the chart a day later, just 1 day before you wrote the grounds pass order and less than 2 days before he died, that he was “paranoid and isolating,” and “crying in his room,” and “convinced his wife was going to take his children, and he would never see them again.” Does that count as “trouble with reality,” doctor?

Psychiatrist: It can.

Attorney: Does it also count as pretty depressed and very probably not motivated to stay alive?

Psychiatrist: I don’t know what you mean.

Attorney: Well, I’m just using your own words, doctor. The things you said would make a patient’s promise or contract unreliable. Unreasonable to rely on.

Psychiatrist: I said that for some patients. Not necessarily for Mr. Smith.

Attorney: Then I’m confused. Didn’t you just describe Mr. Smith in exactly those terms, or agree that the chart, including your assessment, described him in those terms?

Psychiatrist: Some patients can promise.

Attorney: And for those patients, even with Mr. Smith’s diagnosis, and history, and suicidal behavior, you’d actually bet the patient’s life on it?

Psychiatrist: I didn’t say that.

Attorney: A little earlier today, do you recall how you defined the standard of care in this deposition? Do you recall that you used the word “reasonable”?

Psychiatrist: Yes.

Attorney: So is it fair to say that, if it isn’t reasonable for a doctor or a nurse to rely on a no-harm contract for a particular patient, that is, a reasonable doctor or nurse shouldn’t do it but does do it, that person has fallen below the standard of care?

Psychiatrist: ... I think... I guess so.

Attorney: Well, in all fairness, you weren’t guessing earlier, doctor. And I know you’re not a lawyer, but can you answer “yes” or “no” to the question: Has that hypothetical doctor or nurse fallen below what you have already defined as the standard of care?

Psychiatrist: I guess... yes.

Attorney: Thank you for your candor, doctor. I have no further questions. Pass the witness.

If you think that deposition experience, which lasted several hours, was uncomfortable for the psychiatrist-defendant, you’re right. It was also uncomfortable for the administrators of the hospital where the patient died, and for the insurers of each.

This vignette highlights many of the reasons not to rely on a CFS. Let’s list them and a few more, including some indications that the contract itself may be psychologically countertherapeutic. The issues are not as discrete as the bullet points may imply. They should be thoughtfully considered, sometimes in combination, and weighed in individual assessment and care.

- The CFS process may be aimed more at treaters’ and assessors’ anxiety than at competent patient assessment and management.^{6,7}
- Unreasonable reliance on a CFS may shift attention to rote procedures, supplanting more important assessment and counseling procedures.^{8,9}
- A CFS may create an inappropriate sense of security or an impression that further protective measures are unnecessary.
- The patient may agree to the “contract” simply to gain an opportunity to harm himself.
- The patient may agree in order to please the doctor or other caregiver.
- The patient may feel sincere when promising, but his or her feelings or clinical condition may change over hours or days.
- The patient may be sincere when promising but may not be influenced by the promise (or even recall it) a few hours or days later.
- The patient may be sincere in the promise, and recall it, but be unable to keep it. Some suicides are volitional, and many include substantial volitional elements, but preventing suicide is rarely a simple matter of will power or keeping a promise. Patients may plan suicidal activities and wait for opportunities to carry them out, but most lethal suicidal behavior takes place within such hopelessness, pain, and/or disconnection from reality that it is largely outside the patient’s control.^{5,10}
- Regardless of utility, the patient may not be *competent* to make a CFS.
- The CFS may be used as a substitute for a complete assessment and risk-management decision (especially troublesome when the clinician or staff is not well qualified in the first place, or is limited by time or financial constraints).
- The CFS may be used by the clinician or staff in place of (or to avoid) important interventions such as appro-

priate counseling, monitoring, hospital admission, or continued hospitalization. As already mentioned, this is especially troublesome when it is used to make up for poorly qualified staff, limited resources, or lack of therapeutic alliance. The use of CFS has been particularly discouraged when no mature therapeutic alliance has developed (e.g., in emergency departments, acute care units, and brief consultations).^{5,10}

- Even if the above is not the case, the patient may perceive the CFS as a shortcut in his or her care, giving rise to feelings of loss, decreased worth, or deprivation in a person who may be especially vulnerable to those feelings.⁵ A CFS, particularly when used disingenuously, can anger or inhibit patients and introduce coercion into therapy.¹¹

Does a CFS Reduce Malpractice Liability?

There is a certain amount of conventional wisdom—perhaps better described as urban myth—that says a clinician or hospital should have a CFS in the chart in order to diminish liability should a tragedy occur. My experience and the available medical literature suggest otherwise (although I have not performed an exhaustive legal search on the topic). Several forensic psychiatrists have written that CFS alone is a poor defense, and that using one can lead to misplaced clinical and legal confidence. Some facilities and mental health systems make it a policy to seek a CFS for any patient who mentions suicide. While considering a CFS is not necessarily a bad thing in itself, requiring one could distract clinicians and staff from more comprehensive, individualized assessments and interventions.

Several writers describe a value for CFS as part of broader assessment, treatment, and protection. That kind of use is likely to be within the standard of care, particularly in a context of commitment to the overall treatment process (e.g., as described by Rudd et al.¹²). Whether or not overall patient management is acceptable depends on the individual situation. If used, a CFS should be thought of as an enhancement of comprehensive care and risk management, not a substitute for it.⁴

Alliance For Safety, a Better Approach

Clinicians who work with CFS should use them within an *alliance* with the patient—sometimes including other clinicians and caregivers—for the patient's safety. It makes sense that the "alliance" concept should supplant the idea of a contract, since the latter has such potential

for misuse and misunderstanding. Working with and for the patient is the main point, after all. If one's style or purpose suggests putting something in writing, that's fine, so long as the writing doesn't replace adequate care.

The Last Word

Caring for a potentially suicidal patient means doing much more than having the person sign a promise not to attempt suicide. Relying on such a statement in a substantial way when the stakes are as high as life and limb, or allowing it to supplant other appropriate care, is foolish and may be negligent.

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