Contracting for Safety: A Misused Tool



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INTRODUCTION

As a Patient Safety Liaison, I have used my own lessons learned as talking points during some of my initial consultations with healthcare facilities. One of those lessons learned was my knowledge of the limited value of "contracting for safety" or "no-suicide contracts" (NSCs) to prevent suicide. I found through discussions that many healthcare providers use contracts for safety in their assessment of patients at risk for suicide. I also found that many were not aware of the associated limitations and possible risks.

According to the Pennsylvania Department of Health report *Injury Deaths and Hospitalizations in Pennsylvania 2005–2009*, between 2005 and 2009, the age-adjusted suicide rate increased in Pennsylvania by 10%, from 11.1 deaths per 100,000 population to 12.1 deaths per 100,000 population.[1] Between June 2004 and October 2012, healthcare facilities reported 32 deaths by suicide to the Pennsylvania Patient Safety Authority through its Pennsylvania Patient Safety Reporting System (PA-PSRS). These deaths included suicide in the inpatient setting, outpatient setting, and after release from treatment. Additionally, facilities reported 44 events that included the terminology "contract for safety" in the narrative description. Of those 44 events, 8 were reported in which the patient "contracted for safety" but then went on to harm him or herself. Examples include the following:

> *Patient contracted for safety and then ingested hand sanitizer.*
>
> *Patient contracted for safety prior to discharge then committed suicide.*
>
> *Teenage patient contracted for safety and then hung himself.*
>
> *Contracted for safety and immediately removed sutures with a comb.*

The data is limited because reports submitted to PA-PSRS as Infrastructure Failures are not available for review and because the report narratives needed to indicate that the patient had a contract for safety in place in order for the report to be identified by the search of PA-PSRS.

CONTRACTING FOR SAFETY

So what does "contracting for safety" mean, and is it an effective means of assessing a patient's suicide risk? "Contracts for safety," "NSCs," and "no-suicide decisions" are common terms used to describe an agreement between the patient and clinician whereby the patient agrees not to harm him or herself. The agreements are usually written but are sometimes verbal.[2] These terms are often used interchangeably by providers. No-suicide decisions were first described in psychiatric literature by Drye et al. in 1973.[3] The authors described the patient making a decision to not commit suicide for a specified period of time. One of the key aspects of this suicide management strategy was the long-term relationship that the patient had with the clinician. This process has evolved into something very different than what Drye et al. described 40 years ago. NSCs can assist in the patient assessment process but, used alone, can lead to poor or even dangerous treatment plans for the patient.[4,5] It is evident from events reported to the Authority that contracts for safety or NSCs are used in inpatient settings, drug and alcohol units, and emergency departments. The use of such contracts are contraindicated in the emergency setting[6,7] and for use with newly admitted or unknown patients, agitated patients, psychotic or impulsive patients, or those under the influence of drugs or alcohol.[7] Use of NSCs in such settings may ignore the long-term relationship aspect of the contract between the patient and clinician.

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Concerns regarding the use of NSCs include the lack of empirically based evidence to support ongoing use,[2,5,8-14] decreased vigilance by healthcare workers when NSCs are present,[7-9,13,15] inaccurate assumptions of legal protections afforded by NSCs,[5,8,11,13,14] and questions surrounding informed consent and competence.[8,13] A retrospective chart review conducted by Barbara L. Drew in 2001 concluded that contracting for safety did not contribute to suicide; however, prevention of self-harm through the use of NSCs was not demonstrated.[10] The review also concluded that consistent, appropriate nurse staffing levels resulted in a decreased risk of suicide. Some literature suggests that in certain situations (e.g., patient with borderline personality disorder), an NSC may actually increase the patient's risk by putting the patient in a situation that is likely to cause him or her to "act out."[2] Key findings in a qualitative study of crisis team nurses and patients included that clinicians were using NSCs to protect themselves from liability, that clinicians were using NSCs to compensate for limited mental healthcare resources, and that there was a lack of formal training.[14] Other literature suggests that some patients may feel disempowered by an NSC,[15] may see it as a barrier to communicating with clinicians,[13,15] or may be unable to accept additional accountability during such a critical time.[15]

RISK REDUCTION STRATEGIES

Assessing a patient for suicide risk and then managing that risk is one of the more difficult challenges that healthcare workers face. It is difficult to correlate risk reduction strategies and outcomes. Following are some published best practices.

Assessing risk. Conduct a comprehensive psychiatric assessment that includes assessing the five components of suicide (ideation, intent, plan, access to lethal means, and history of past attempts);[7,9,16] evaluate risk factors, noting those that can be modified to reduce risk;[7,9,16,17] examine the patient's current situation (what is happening now);[16] identify protective factors, noting those that can be enhanced;[17] develop a safety/crisis plan with the patient;[5,7,18] and identify appropriate interventions. Risk factors include the following:

- Presence of a mental health disorder (high-risk diagnoses include major depression, bipolar disorders, alcohol or substance abuse, schizophrenia, and borderline personality disorder)[7,9,16,17]
- Delirium[9]
- Dementia[9]
- Other cognitive impairment[7,16,17]
- Social stressors (e.g., financial)[7,9,17]
- Recent or impending loss[17]
- Access to firearms[7,9,17]
- Previous suicidal behavior or attempts[7,9,16,17]
- History of physical or sexual abuse[16,17]
- Family history of suicide[7,9,16,17]
- Social isolation[7,16]
- Hopelessness or despair[7,9,16,17]
- Anhedonia[16,17]
- Impulsivity[7,16,17]
- Global insomnia[17]
- Command hallucinations[16,17]
- Medical disorders with poor prognosis, poor physical functioning, or chronic pain[7,9,16,17]
- Childhood trauma[7,16,17]

Consideration should also be given to special populations such as adolescents and the elderly, certain occupations, and demographics.[7,16,17]

Assessing at appropriate times. Suicide risk assessment and reassessment is a dynamic process. Opportunities to assess risk include upon crisis presentation to a mental health or emergency setting, during initial psychiatric inpatient or outpatient evaluation, when a change in observation status or treatment setting is being considered, when the patient's clinical presentation changes, when there is a lack of improvement or worsening of symptoms while receiving treatment, when medications are changed, when a significant other becomes involved, prior to discharge, and when a patient with a chronic mental health disorder stops treatment.[16,17]

Managing risk. Establish and maintain a therapeutic relationship; provide a safe environment; determine the appropriate treatment setting; develop a treatment plan with the patient;[7,17] develop a safety/crisis plan with the patient;[5,8,18] coordinate, consult, and collaborate with other clinicians; promote adherence to the plan; educate the patient and family;[7] provide emergency contact numbers (both local and national) and instructions on when to call;[17,18] and monitor patient status and response to treatment.[7]

CONCLUSION

Little evidence exists to support the use of NSCs. However, if they are used, it is important to ensure that they are used appropriately in the management of suicide risk. NSCs are intended for use in settings where there are longstanding therapeutic relationships with the clinicians, and they are not intended to replace comprehensive suicide risk assessments.

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NOTES

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