Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 8, Issue, 09, pp.38969-38973, September, 2016

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

ISSN: 0975-833X

RESEARCH ARTICLE

INPATIENT SUICIDE: RELIANCE AND RELIABILITY OF "NO SUICIDE CONTRACTS"

[1]Hema Venigalla, [2]Hema Madhuri Mekala, [3]Mudasar Hassan, [4]Sara Rehman Noor and *,[5]Saeed Ahmed

[1]Texas Behavioral Health Clinic –TX
[2]University of Missouri – MO
[3]A & I Physicians PLLC, Brooklyn - New York
[4]Texas Behavioral Health Clinic –TX
[5]Nassau Medical University Hospital- New York

ARTICLE INFO

Article History:
Received 19th June, 2016
Received in revised form
19th July, 2016
Accepted 21st August, 2016
Published online 30th September, 2016

Key words:

Inpatient suicide,
No suicide contract,
Risk assessment of psychiatric patients Introduction.

ABSTRACT

Suicide is the seventh leading cause of death in the US. An estimate of 37,000 people dies every year by suicide in the US, of which 6 percent are attributed to inpatient suicide. Despite taking certain measures to prevent inpatient suicide like assessing the risk factors and treating the underlying psychiatric condition appropriately, continuous monitoring and making patients sign no-suicide contracts, the rate has not decreased significantly. Sixty-five percent of people who commit inpatient suicide sign the no-suicide contract beforehand. This reflects that these contracts are less effective in reducing the inpatient suicide rate. Moreover, such contracts can give an impression to the patients regarding mistrustful attitudes from the doctor's or therapist's side. These contracts can also provide a false sense of security to psychiatrists and decrease their clinical vigilance. Also, these contracts do not protect the physicians from malpractice judgments if lawsuits occur. Also, if we think a signed contract can give a positive incentive for the patient to avoid suicide, this could have been achieved with just good counseling and therapy to reinforce the strength of self-controlling themselves and decrease suicidal ideation. Rather, it is essential to focus on proper suicide assessment, accurate and safe monitoring of high-risk patients and removing environmental dangers. Most importantly psychiatrists should make sure to develop a good therapeutic alliance with the patients to prevent and decrease inpatient suicidal rates instead of entirely relying on no suicide contracts. In this paper, we will review risk factors for inpatient suicide, the validity of the risk assessment, strategies to prevent inpatient suicide, and we will later discuss the reliability of no-suicide contracts to prevent suicide.

Citation: Hema Venigalla, Hema Madhuri Mekala, Mudasar Hasan, Sara Rehman Noor and Saeed Ahmed, 2016. Inpatient suicide: Reliance and reliability of "no suicide contracts", *International Journal of Current Research*, 8, (09), 38969-38973.

INTRODUCTION

Suicide is the significant mental health burden in the society at present. According to WHO data, suicide is the 15th leading causing death in 2012 world-wide but the rates are rapidly increasing. Based on the international suicide statistics, suicide rates have increased 44 percent in the last 60 years. Due to religious and social stigma, many suicides are under reported, so the actual rates are surely much more than reported. Although the majority of the suicides do happen out of the hospital setting, though inpatient suicides, especially in psychiatric units, do contribute to a significant number of the total suicides. The inpatient suicide rate range is 5-15 and 100-400 per 100,000 admissions in general and in psychiatric hospitals, respectively (Cheng *et al*., 2009). The majority of the inpatient suicides are attributed to patients with mental health illnesses that commonly include affective disorders, depressive symptoms, anxiety disorder, schizophrenia and previous self-harm (Bowers *et al*., 2008; Combs and Romm, 2007; Larg *et al*., 2011). The same fact is reinforced by a study which showed approximately 52 percent of the patients admitted to psychiatric units had suicide attempts and completed suicides combined compared to less than 10 percent in other units (Mills *et al*., 2008). The poor risk assessment and inefficient patient monitor are identified by many studies as the causative factor which may lead to suicide on the inpatient units, or shortly after discharge (Bowers *et al*., 2008; Combs and Romm, 2007; Larg *et al*., 2011. The Joint Commission's Sentinel Event database reported that 1,089 suicides occurred

Corresponding author: Saeed Ahmed,
Nassau Medical University Hospital- New York.

from 2010 to 2014 among inpatients admitted in a safe monitored setting under the supervision of well-trained staff, including those from a hospital's emergency department. The most important and primary cause found during this period was an inadequate psychiatric assessment (Commission, 2016). Many health organizations not only in the United States but all around the globe don't have adequate suicide prevention strategies and resources. It is seen that detection and treatment those are at risk turn out to be compromised because of heavy workload and lack of safeguards at the time admission, course of hospitalization or at the time discharge. Historically, the guidelines by numerous governing bodies including American Psychiatric Association mainly focus on assessing and treating suicidal behavior in the outpatient setting, but yet we lack concrete consensual strategy, risk assessment of suicide in inpatient settings. Many strategies have been under implementation to prevent inpatient suicide for past few decades but no single strategy is demonstrated significant enough to reduce the rate. A well-known strategy is the "No suicide contract." The no suicide contract is an agreement that is designed for the patients to sign by medical professionals to prevent suicide (Simon, 1999). These contracts have been in clinical practice since 1973 in the United States (Rudd *et al*., 2006). The main objective of such a contract is to give the patients motivation that it is never approved to commit suicide and rather they always should seek help in such a situation.

Risk factors for Inpatient suicide and validity of risk assessment

As we know, suicide generally is considered to be the result of a combination of risk factors. Inpatient suicides may also carry the same risk factors in addition to few others, specific to the setting or environment. The common risk factors considered for inpatient suicide include male gender, history of previous suicide assessments, emotional difficulties, poor relationships with family and staff, and implementation of violent methods in an attempt to commit suicide previously (Cheng *et al*., 2009). In addition, other associated factors like older age, having a chronic physical condition like pain or terminal illness, family history of suicide attempts and completions should be considered as well (Cheng *et al*., 2009). Also, psychopathology of the disease, especially for psychiatric illnesses like depression, schizophrenia (Li *et al*., 2008) and other affective disorders, is an important risk factor that is to be considered (Large *et al*., 2011; Bowers *et al*., 2010). Moreover, co-morbidities like anxiety and agitation should be regarded as equally important in the risk assessment and never underestimated (Busch *et al*., 2003). Similarly, patients with treatment-resistant cases and patients suffering serious side-effects from the medications are to be given prime importance and monitored carefully (Neuner *et al*., 2008). The primary risk factor for inpatient suicide, which is always under-emphasized, is the intimidating experience for the patients to be around in a new environment with other mentally ill patients which might increase suicidal ideation during this period (Bose *et al*., 2016). A study has concluded that inpatient suicides mainly occur due to the inherent factors in that hospitalization (Large *et al*., 2014). Also, studies have demonstrated that patients who are hospitalized for longer periods are at risk for suicide by getting sick of the surrounding environment (Neuner *et al*., 2008). Finally, the important risk factor to prevent inpatient suicide is the failure of health care system. Suicide prevention in hospitals certainly has few loopholes involving the lack of a systematic approach towards patient care, inadequate application of rules, poor training of the new staff and barriers between patients and health care professionals. The failures in the system mainly include improper assessment of the patients, lack of comprehensive treatment plans and evaluation of past records, lack of proper monitoring and supervision, lack of providing medications promptly for symptom alleviation, lack of repeated assessment of suicide intents and documentation in each shift. The other crucial thing which is always disregarded is the elimination of harmful objects like belts, shoelaces, plastic bags and periodic checks to remove them from the patient's sight (Jayaram, 2014). The nursing staff comprises the health care personnel that get to work in close collaboration with the patients. Their feedback is important in such scenarios to understand the facts and act accordingly to prevent the occurrence of the same flaws in the future. Studies conducted previously featuring nursing staff concluded that there is surely certain ambiguity considering the care provided in preventing inpatient suicide, which included organizational issues, lack of autonomy and consistency in the nursing staff, lack of resources and supporting structure leading to decreasing the quality of the care (James *et al*., 2012). The next important risk factor which is always overlooked is not taking appropriate measures considering the transition of care to the out-patient setting after discharge. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely manner following discharge from emergency room or inpatient psychiatric units (Knesper, 2011). The risk of suicide is three times as likely in the first week after discharge from a psychiatric facility (Siegfried and Bartlett, 2014) and continues to be high especially for the next four years after discharge (Allen *et al*., 2013). Risk assessment for suicide is considered an important criterion for psychiatric inpatients. But it is always challenging how valid the assessment is, considering the complexity of all the risk factors taken together. Firstly, categorizing the patients into high or low risk based on the assessing factors like previous suicide attempts, depression or denial of suicidal thoughts, signing no suicide contracts respectively is a fallacy. Every patient has different independent risk factors for suicide even after they deny orally the same, considering their mental incapacitation. All patients admitted to the psychiatry units have a unique presentation and congruence of risk factors involved which should not be overlooked or undervalued. Also demographic, environmental factors are to be considered for the risk assessment (Large *et al*., 2011). Studies conducted previously on several patients have proved that there is no consistent set of risk factors to assess and eventually prevent inpatient suicide.

Approximately, 25 percent of suicidal patients deny suicidal ideation when asked (Simon, 2011). Likewise, studies also showed that there is no statistical significance between the expression of suicidal ideation and actual inpatient suicide completion (Large *et al*., 2011). Henceforth, the validity and reliability of standard risk assessment for suicide for all the patients are unreliable. Rather, a systematic assessment of each patient considering his or her risk factors independently can be more valid and reliable.

Table 1. Risk factors for inpatient suicide

Immediate risk factors	Long term risk factors	Nosocomial risk factors	
•Young age group	•Old age group	IMMEDIATE	LONG TERM
•Male gender	•Chronic pain		
•History of previous attempts	•Terminal illness	•Intimidating experience in new environment	•Poor relation with the nursing staff and other health care personnel
•Present emotional state of severe depression	•Family history of suicide attempts	•Improper psychiatric assessment	
•History of alcohol and other substance abuse	•Psychopathology of psychiatric illnesses	•Lack of safe monitoring measures	•Lack of comprehensive treatment
• Implementation of violent methods in the past to attempt suicide	•Side effects from the medication	•Removal of environmental hazards	•Lack of repeated assessment of suicidal thoughts

Table 2. Strategies to prevent inpatient suicide

Strategies for acute prevention of inpatient suicide	Long term prevention of inpatient suicide	Strategies to prevent suicide post-discharge
•Adequate psychiatric assessment of the patient	•Appropriate training of the nursing staff	•Educating patients and family to establish outpatient psychiatric care
•Vigilant timely monitoring by nursing staff	•Periodic check for environmental hazards	•Increasing awareness among patients regarding compliance
•Removal of environmental hazards	•Development of good therapeutic alliance with the patient	•Encouraging patients to continue with psychotherapy post discharge
•Obtaining collateral history from the family	•Avoidance of overlooking low risk patients	•Educating the family regarding ensuring appropriate care

Strategies to prevent Inpatient suicide

Suicide in a hospital setting is the most alarming concern for psychiatrists. It is the most important duty of mental health professionals to prevent suicide in hospitalized patients, where patients and families of patients are assured of safety. Necessarily, prevention of inpatient suicide cannot be achieved with any single strategy. In the light of past experiences and published evidence, environmental safety is the stronghold of inpatient suicide prevention. A study, in which 113 VA facilities tested the Mental Health Environment of Care Checklist to assess mental health units and identified 7,642 environmental hazards which pose the risk of inpatient suicide. At the end of one year of study, participating facilities abated 5834 hazards, 2 percent were ranked as critical, 27 percent were identified was serious. The most common environmental factors recognized as the greatest risk factor were hanging objects, structures close to the floor, objects of strangulation, locations such as bathrooms and bedrooms (Mills *et al*., 2010; Puntil *et al*., 2013). It has to be a collaborative strategic plan comprising all the health care professionals in the team managing the patient. The patient population admitted to the psychiatry unit, irrespective of diagnosis, has to be assessed carefully for the risk factors. Later the high-risk patients need a vigilant monitoring from the staff. The staff also should be well-trained with careful monitoring without any negligence. Overtly, relying on a 15-minute watch should be avoided. It is also important to work on improving staff-patient relationships and the communications skills of the staff to have a better understanding. Most essentially, ensuring a safe environment without any physical attempts to commit suicide is very crucial. The psychiatric units are to be periodically monitored to check for any such environmental hazards (Association, 2006; De Leo and Sveticic, 2010; Knoll, 2013). Mainly, outside visits have to be minimized, and patients should be monitored carefully during their visits outside the wards as most of the inpatient suicides occur during this time (Cheng *et al*., 2009). Visitors should be searched thoroughly before they meet patients because visitors may or may not understand the complexity of a patient's mental illness, and they might provide any instrument of daily living like razor, laces of shoes, etc. which can later be used as a tool for attempting suicide. Psychiatrists also have to be vigilant on monitoring changes in behavioral signs and symptoms and also wait for significant, reliable change to unwind the precautions. Also, instead of entirely relying on the information from the patient, it is always essential to get collateral information from the staff and also patient's family on a daily basis. Not often but sometimes, patients may not express their suicidal thoughts, intent or plan with the psychiatrist but might share their thoughts with family or other staff members. Finally, untimely premature discharges have to be avoided, and a smooth transition to the outpatient care is vital (Association, 2006; De Leo and Sveticic, 2010; Knoll, 2013). Several studies showed that various therapeutic approaches aid in reducing the suicidal ideation after discharge which include Cognitive Therapy for Suicide Prevention (Brown *et al*., 2005; Stanley *et al*., 2009), Collaborative Assessment and Management of Suicide (Jobes, 2015; Comtois *et al*., 2011) and Dialectical Behavior Therapy (Linehan *et al*., 2006). In addition, caring contacts providing appropriate care after discharge is considered an effective prevention strategy (Luxton *et al*., 2013). No-suicide contracts are thought to be a strategy to prevent inpatient suicide for the past few decades. Nevertheless, patients having signed such contracts is not a reliable approach for suicide prevention and has many limitations (Kroll, 2007). Studies have shown that there is limited evidence that such contracts reduce the suicidal risk in the patients. In a survey conducted with 267 psychiatrists, 41 percent reported that they had patients who committed suicide or made a serious attempt even after signing the contract (Kroll, 2000). Recently, few studies proved that routine use of no-suicide contracts is neither prevention nor an assessment tool. Nor do these provide any legal protection in the advent of suicide completion or any serious attempt (Stanford *et al*., 1994; Berman *et al*., 2000).

DISCUSSION

Inpatient suicide definitely is the most avoidable and preventable psychiatric emergency. But surely, "no suicide contracts" are not a reliable approach to achieving that. Such contracts have a negative impact on the patients and also give false assurance to health care professionals. The patients, who are already going through serious psychiatric illnesses, might consider that their health care providers don't trust them which may weaken the patient-doctor relationship. Also, psychiatrists and other nursing staff might also not pay their full attention towards the patients due to the pious hope they have from having patients sign such contracts. Also, such contracts providing legal protection should the suicide be completed is a misconception. Moreover, when dealing with psychiatric patients considering the diagnostic spectrum like schizophrenia or depression–most often suicidal ideations are driven due to psychological or impulsive reasons. This implies that such patients when signing no suicide contracts are not mentally stable. So relying on such contracts signed by patients who are mentally instable and thinking that these contracts may prevent suicide is not logical. And also, making the patients sign such contracts when admitted in inpatients units during the acute phase of the illness is ineffective in practical purposes. In addition to focus on assessing the risk factors, treating and monitoring the patients appropriately and ultimately developing a good therapeutic alliance with the patient stays the highest priority. It may be an option to make the patients sign "no-suicide contracts" when they are mentally stable after the discharge with a detailed discussion including the patient and family. But again, the reliability of such contracts in preventing suicide for acutely mentally ill patients is always a challenging question. So in conclusion, it is the critical responsibility of the psychiatrists and other staff in the unit comprehensively to work in congruence with the organizations towards preventing inpatient suicide with appropriate care and management rather than relying on such contracts.

REFERENCES

Allen MH, Abar BW, McCormick M, Barnes DH, Haukoos J, Garmel GM, *et al*. 20133. Screening for suicidal ideation and attempts among emergency department medical patients: instrument and results from the Psychiatric Emergency Research Collaboration. Suicide and Life-Threatening Behavior. 43(3):313-23.

Association AP. 2006. American Psychiatric Association Practice Guidelines for the treatment of psychiatric disorders: compendium 2006: American Psychiatric Pub.

Berman AL, Silverman MM, Bongar BM. 2000. Comprehensive textbook of suicidology: Guilford Press.

Bose S, Khanra S, Umesh S, Khess CR, Ram D. 2016. Inpatient suicide in a psychiatric hospital: Fourteen years' observation. *Asian Journal of Psychiatry*, 19:56-8.

Bowers L, Banda T, Nijman H. 2010. Suicide inside: a systematic review of inpatient suicides. *The Journal of Nervous and Mental Disease*, 198(5):315-28.

Bowers L, Nijman H, Banda T. 2008. Suicide inside: A literature review on inpatient suicide. London, England: Department of Mental Health and Learning Disability. City University.

Brown GK, Ten Have T, Henriques GR, Xie SX, Hollander JE, Beck AT. 2005. Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. Jama. 294(5):563-70.

Busch KA, Fawcett J, Jacobs DG. 2003. Clinical correlates of inpatient suicide. *Journal of Clinical Psychiatry*, 64(1): 14-9.

Cheng I-C, Hu F-C, Tseng M-CM. 2009. Inpatient suicide in a general hospital. *General Hospital Psychiatry*, 31(2):110-5.

COMBS H, ROMM S. 2007. Psychiatric inpatient suicide: A literature review. *Primary Psychiatry*, 14(12):67-74.

Commission J. 2016. Detecting and treating suicide ideation in all settings. Sentinel Event Alert [serial on the Internet] Oak Brook (IL): Joint Commission.

Comtois KA, Jobes DA, S O'Connor S, Atkins DC, Janis K, E Chessen C, *et al*. 2011. Collaborative assessment and management of suicidality (CAMS): feasibility trial for next-day appointment services. Depression and Anxiety. 28(11):963-72.

De Leo D, Sveticic J. 2010. Suicides in psychiatric in-patients: what are we doing wrong? Epidemiologia e psichiatria sociale. 19(01):8-15.

James K, Stewart D, Bowers L. 2012. Self-harm and attempted suicide within inpatient psychiatric services: A review of the Literature. *International Journal of Mental Health Nursing*, 21(4):301-9.

Jayaram G. 2014. Inpatient suicide prevention: promoting a culture and system of safety over 30 years of practice. Journal of Psychiatric Practice®. 20(5):392-404.

Jobes DA. 2015. The CAMS approach to suicide risk: philosophy and clinical procedures. Suicidologi. 14(1).

Knesper DJ. 2011. Continuity of Care for Suicide Prevention and Research: Suicide Attempts and Suicide Deaths Subsequent to Discharge from an Emergency Department Or an Inpatient Psychiatry Unit: Suicide Prevention Resource Center.

Knoll JL. 2013. Inpatient suicide: identifying vulnerability in the hospital setting. Psychiatric Times. 30(6):36-.

Kroll J. 2007. No-suicide contracts as a suicide prevention strategy. *Psychiatric Times*., 24(8):60-.

Kroll J. 2000. Use of no-suicide contracts by psychiatrists in Minnesota. *American Journal of Psychiatry*, 157(10): 1684-6.

Large M, Ryan C, Nielssen O. 2011. The validity and utility of risk assessment for inpatient suicide. *Australasian Psychiatry*, 19(6):507-12.

Large M, Smith G, Sharma S, Nielssen O, Singh SP. 2011. Systematic review and meta-analysis of the clinical factors associated with the suicide of psychiatric in-patients. Acta Psychiatrica Scandinavica. 124(1):18-9.

Large MM, Ryan CJ. 2014. Disturbing findings about the risk of suicide and psychiatric hospitals. Social psychiatry and psychiatric epidemiology, 49(9):1353.

Li J, Ran MS, Hao Y, Zhao Z, Guo Y, Su J, *et al*. 2008. Inpatient suicide in a Chinese psychiatric hospital. Suicide and life-threatening behavior, 38(4):449-55.

Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, *et al*. 2006. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and

borderline personality disorder. *Archives of General Psychiatry*, 63(7):757-66.

Luxton DD, June JD, Comtois KA. 2013. Can postdischarge follow-up contacts prevent suicide and suicidal behavior? Crisis.

Mills PD, DeRosier JM, Ballot BA, Shepherd M, Bagian JP. 2008. Inpatient suicide and suicide attempts in Veterans Affairs hospitals. *The Joint Commission Journal on Quality and Patient Safety*, 34(8):482-8.

Mills PD, Watts BV, Miller S, Kemp J, Knox K, DeRosier JM, *et al*. 2010. A checklist to identify inpatient suicide hazards in Veterans Affairs hospitals. *The Joint Commission Journal on Quality and Patient Safety*, 36(2):87-93.

Neuner T, Schmid R, Wolfersdorf M, Spie ßl H. 2008. Predicting inpatient suicides and suicide attempts by using clinical routine data? *General Hospital Psychiatry*, 30(4):324-30.

Puntil C, York J, Limandri B, Greene P, Arauz E, Hobbs D. 2013. Competency-Based Training for PMH Nurse Generalists Inpatient Intervention and Prevention of Suicide. *Journal of the American Psychiatric Nurses Association*, 19(4):205-10.

Rudd MD, Mandrusiak M, Joiner Jr TE. 2006. The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology*, 62(2):243-51.

Siegfried N, Bartlett M, editors. 2014. Navigating suicide assessment: A roadmap for providers. A presentation at The Joint Commission's 2014 Annual Behavioral Health Care Conference.

Simon RI. 2011. Improving suicide risk assessment: avoiding common pitfals. Psychiatric times. 28(11):16-.

Simon RI. 1999. The suicide prevention contract: clinical, legal, and risk management issues. *Journal of the American Academy of Psychiatry and the Law Online*. 27(3):445-50.

Stanford EJ, Goetz RR, Bloom JD. 1994. The No Harm Contract in the emergency assessment of suicidal risk. Journal of Clinical Psychiatry.

Stanley B, Brown G, Brent DA, Wells K, Poling K, Curry J, *et al*. 2009. Cognitive-behavioral therapy for suicide prevention (CBT-SP): treatment model, feasibility, and acceptability. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48(10):1005-13.

****