Discharging your patients who display contingency-based suicidality: 6 steps

Christopher Bundy, MD, MPH, Matthew Schreiber, MD, PhD, and Marcella Pascualy, MD

Discharging patients from a hospital or emergency department despite his (her) ongoing suicidal ideation is a clinical dilemma. Typically, these patients do not respond to hospital care and do not follow up after discharge. They often have a poorly treated illness and many unmet psychosocial and interpersonal needs.[1] These patients may communicate their suicidality as conditional, aimed at satisfying unmet needs; secondary gain; dependency needs; or remaining in the sick role. Faced with impending discharge, such a patient might increase the intensity of his suicidal statements or engage in behaviors that subvert discharge. Some go as far as to engage in behaviors with apparent suicidal intent soon after discharge.

A complicated decision

Such patients often are at a chronically elevated risk for suicide because of mood disorders, personality pathology, substance use disorder, or a history of serious suicide attempt.[2] Do not dismiss a patient's suicidal statements; he is ill and may end his own life.

Managing these situations can put you under a variety of pressures: your own negative emotional and psychological reactions to the patient; pressure from staff to avoid admission or expedite discharge of the patient; and administrative pressure to efficiently manage resources.[3] You're faced with a difficult decision: Discharge a patient who might self-harm or commit suicide, or continue care that may be counterproductive.

We propose 6 steps (***Table; page e2***) that have helped us promote good clinical care while documenting the necessary information to manage risk in these complex situations.

1. Define and document the clinical situation. Summarize the clinical dilemma.

2. Assess and document current suicide risk.[4] Conduct a formal suicide risk assessment; if necessary, reassess throughout care. Focus on dynamic risk factors; protective risk factors (static and dynamic); acute stressors (or lack thereof) that would increase their risk of suicide above their chronically elevated baseline; and access to lethal means—firearms, stockpiled medication, etc.

3. Document modified dynamic or protective factors. Review the dynamic risk and protective factors you have identified and how they have been modified by treatment to date. If dynamic factors have not been modified, indicate why and document the recommended plan to address these matters. You might not be able to provide relief, but you should be able to outline a plan for *eventual* relief.

4. Document the reasons continued care in the acute setting is not indicated. Reasons might include: the patient isn't participating in recommended care or treatment; the patient isn't improving, or is becoming worse, in the care environment; continued care is preventing or interfering with access to more effective care options; is counterproductive to the patient's stated goals; or compromising the safety benefit of the structured care environment because the patient is not collaborating with his care team.

5. Document your discussion of discharge with the patient. Highlight attempts to engage the patient in adaptive problem solving.

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Dr. Bundy is Director, Acute Care Services, VA Puget Sound Health Care System and Assistant Professor, University of Washington School of Medicine, Seattle, Washington.
Dr. Schreiber is Staff Psychiatrist, VA Puget Sound Health Care System and Assistant Professor, University of Washington School of Medicine, Seattle, Washington.
Dr. Pascualy is Chief, Inpatient Consultation-Liaison Service, VA Puget Sound Health Care System, Director, Psychosomatic Fellowship Program, and Associate Professor, University of Washington School of Medicine, Seattle, Washington.

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Discuss and document a follow-up plan and make direct contact with providers and social supports

Table

6 Steps for managing and documenting contingency-based suicidal ideation

Step 1: Define and document the situation.

Example A	Example B
This is the seventh hospital discharge for Mr. K, age 50. He reports suicidal thoughts and says that if he is discharged he will kill himself by jumping off a bridge. Mr. K says that, to be safe, he will need stable housing and resolution of his pain. He is not adherent to the team's recommendations, is not participating in groups or programming on the unit, and often is uncooperative with care.	Mr. J, age 45, has presented to the emergency department 4 times in the past 2 months, complaining of suicidal ideation with a plan and intent in the context of intoxication or withdrawal from opiates and alcohol. This has resulted in 2 earlier hospitalizations without benefit. Mr. J has not attended outpatient ambulatory treatment center (ATC) appointments after discharge. Mr. J insists that if he is not admitted to the hospital today, he will end his life. He is refusing alternatives to hospitalization, including an appointment tomorrow in ATC and referral and transportation to detox or a shelter today.

Step 2: Assess and document current suicide risk.

- Examine static risk factors, dynamic risk factors, and protective risk modifiers (static and dynamic).
- Ask if the patient has access to highly lethal means (eg, firearms, stockpiled medication).
- Differentiate acute risk from chronic risk.
- Interpret contingency-based suicidal statements (when applicable).

Example

For Mr. K, his age, male sex, white race, low-social support, mood disorder, substance use disorder (SUD), and chronic pain might be associated with an increased risk of suicide. Of these, mood disorder, social support, SUD, and chronic pain potentially are modifiable. Factors that may be protective against suicide for Mr. K include: religious prohibition, lack of recent high lethality attempt, and a history of self-protection after suicidal behavior (calling a suicide hotline or 911, coming to the emergency department), and no ready access to firearms. Most, if not all, of Mr. K's suicide risk factors are chronic.

Given these considerations and the lack of any new or acute additional stressor, Mr. K's short-term risk of suicide is low relative to his chronic, moderately elevated, suicide risk profile. His statement that he will kill himself if discharged appears to be an expression of unmet needs (housing, pain management) that is representative of his limited and often-maladaptive coping and skills, rather than an indicator of imminent risk of death.

Step 3: Document how dynamic or protective factors have been modified or addressed in current (and prior) treatment.

- Review the identified dynamic risk and protective factors and how they've been modified by treatment to date.
- If dynamic factors have not been mitigated, indicate why and document the recommended plan to address these.
- Outline a plan for relief.

Example A	Example B
During this hospital stay, Mr. K has demonstrated improved mood—engaging with other patients and getting adequate sleep, regaining appetite, and participating in self-care activities. Mr. K has been detoxified from opiates and alcohol but has declined treatment for his SUD. The clinical team attempts to manage his pain; although he continues to report inadequate relief, it doesn't appear to be significantly limiting his functioning or activities of daily living and is not associated with autonomic hyper-arousal consistent with unbearable pain. Long-term outpatient follow-up has been arranged. Mr. K is unable to identify social supports for the team to contact to assist him in the short-term, however, he is refusing to participate in more formalized treatment groups. Mr. K has accepted spiritual counseling from a chaplain.	Mr. J has been observed in the emergency department and is now sober. He continues to refuse interventions—outpatient substance treatment, referral to detox center, or shelter support overnight—to address modifiable factors that are increasing his risk of suicide.

continued

Step 4: Document why continued care is not indicated.

- The patient is not participating in recommended care or treatment.
- The patient is not improving, or getting worse, in the care environment.
- Continued care is preventing or interfering with access to more effective care options or is counterproductive to stated goals.
- There is a lack of collaboration with the treatment team that mitigates the safety benefit of a structured care environment.

Example A

Mr. K is unwilling to participate in any interventions. His treatment goals of housing and pain relief are unobtainable in the short-term inpatient setting. Any safety benefit of hospitalization is mitigated by his lack of collaboration and engagement with the treatment team. Continued treatment in the hospital is delaying his engagement with outpatient services and the period during which he must demonstrate outpatient stability to be eligible for housing. Continued hospitalization is no longer benefiting him and may be unnecessarily delaying effective intervention.

Example B

Mr. J has not benefited from past hospitalizations under similar circumstances in terms of suicide risk modification or improvement in his mental health or social conditions. His repeated use of emergency department and inpatient services instead of recommended outpatient follow-up is ineffective in helping him improve. Inpatient hospitalization is not indicated, and Mr. J is refusing interventions that the team has offered to him in the emergency department to mitigate his risk of self-harm, other than allowing us to observe him to sobriety. Referral to a county-designated mental health professional is not indicated, despite the patient's suicidal statements, because detainment to the hospital will result in further treatment that is unlikely to help him.

Step 5: Document your discussion of the treatment rationale with the patient and the patient's understanding of the discussion, including the absence of factors that would impair volition.

Example

"I have discussed my assessment and treatment recommendations with the patient. Further, I see no evidence of severe psychosis, cognitive impairment, intoxication, or other condition that prevents the patient from acting under his own choice and volition. As such, I have counseled the patient that he retains the ability to not kill himself and follow-up with recommended treatment and that a decision to end his life is ultimately his responsibility. Although he is angry and does not engage in productive discussion around the issues, I believe Mr. K has good understanding of the treatment recommendations and is appropriate for discharge."

Step 6: Seek consultation from a colleague, document the discussion, and add him (her) as a signer to the note.

Work out a crisis or suicide safety plan and give the patient a copy and keep a copy in his (her) chart.

If the patient refuses to engage in safety planning, document it in the chart. Note the absence of any conditions that might impair the patient's volitional capacity to not end their life—intoxication, delirium, acute psychosis, etc. Explicitly frame the patient's responsibility for his life. Discuss and document a follow-up plan and make direct contact with providers and social supports, documenting whether contacting these providers was successful.

6. Consult with a colleague. An informal non-visit consultation with a colleague demonstrates your recognition of the complexity of the situation and your due diligence in arriving at a discharge decision. Consultation often will result in useful additional strategies for managing or engaging the patient. A colleague's agreement helps demonstrate that "average practitioner" and "prudent practitioner" standards of care have been met with respect to clinical decision-making.

References

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