

# The Suicide Prevention Contract: Clinical, Legal, and Risk Management Issues

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**In the managed care era, mental health professionals increasingly rely upon suicide prevention contracts in the management of patients at suicide risk. Although asking a patient if he or she is suicidal and obtaining a written or oral contract against suicide can be useful, these measures by themselves are insufficient. "No harm" contracts cannot take the place of formal suicide risk assessments. Obtaining a suicide prevention contract from the patient tends to be an event whereas suicide risk assessment is a process. The suicide prevention contract is not a legal document that will exculpate the clinician from malpractice liability if the patient commits suicide. The contract against self-harm is only as good as the underlying soundness of the therapeutic alliance. The risks and benefits of suicide prevention contracts must be clearly understood.**

In the managed care era, mental health professionals increasingly rely upon suicide prevention contracts in the management of patients at suicide risk.<sup>1</sup> In both outpatient and inpatient settings, patients are being treated for shorter periods of time. For example, in acute care psychiatric units or hospitals, the average length of stay is usually less than six days. However, only the sickest patients are hospitalized.<sup>2</sup> The purpose of hospitalization is rapid stabilization of the patient and early discharge. Admission requirements for in-

patient treatment often exceed substantive criteria for involuntary commitment.

Under these limitations, the therapeutic alliance, which is the stock-in-trade of mental health practitioners, has little time to develop. The treatment team, working in conjunction with the psychiatrist, has often become the primary care provider for inpatients. If the patient is capable of developing a therapeutic alliance, it is usually with the team or possibly with the hospital itself. In the outpatient setting, the therapeutic alliance may be attenuated by fewer, briefer visits with an often increased reliance on medications. The presence of a viable therapeutic alliance forms the basis for reliance upon a suicide prevention contract. However, the therapeutic alliance is a dynamic interaction that is in constant flux.

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## Clinical Issues

The intended purpose of the suicide prevention contract is to provide safety in the management of the patient at suicide risk. The agreement provides explicit information about the availability of the treatment provider (e.g., answering service or "beeper" numbers). The agreement may simply state:

We (clinician and patient) agree that you (patient) will call me if you find that you are worrying about harming yourself. If you feel you need immediate help and cannot reach me at that moment, you will go directly to the emergency room (specifically designated). If you need to be seen between appointments, I will be available to see you.

The suicide prevention contract promises too much if it states that the clinician will be available at all times—an obvious impossibility for outpatients. For inpatients, the suicide prevention contract should emphasize the availability of clinical staff on the unit. Although some therapists require the patient to sign such a statement, the patient's signature is not crucial. The therapist may obtain an oral contract against suicide. However, the existence and terms of an oral agreement should be recorded in the patient's chart.

Suicide prevention contracts can be useful in certain instances as part of the assessment of the therapeutic alliance, but their limitations should be clearly understood.<sup>3,4</sup> The problem with the patient contract against suicide is that it may falsely relieve the practitioner's concern and lower clinical vigilance without having any beneficial effect on the patient's suicidal intent. There may be little or no basis to rely upon a suicide prevention contract obtained from a new patient who

is at suicide risk. The psychiatrist may not have had sufficient time to adequately assess the patient, especially the patient's capacity to form a therapeutic alliance. Moreover, a patient who is "determined" to commit suicide may sign such a contract to avoid the detection of suicidal intent. Forensic psychiatrists who have reviewed numerous suicide cases can confirm that the road to suicide is strewn with broken suicide prevention contracts and unkept promises against suicide by patients. Relying upon "no harm" contracts may reflect the clinician's unrealistic attempt to control the inevitable anxiety associated with treating patients at suicide risk.

Some clinicians gauge the patient's suicidal intent by his or her willingness or unwillingness to formalize the alliance by a written contract.<sup>5</sup> Although some patients will accept a suicide prevention contract, some will state openly that they cannot be sure that if self-destructive impulses threaten, they can or will want to call the therapist. Suicide prevention contracts that are declined by the patient often provide the most credible information about the state of the therapeutic alliance and level of suicide risk. Patients who refuse outright to commit to contracts against suicide may at least disabuse the clinician of a false sense of security. Although the refusal to agree to such a contract may not mean that the patient is imminently suicidal, the clinician is on notice that the therapeutic alliance should be reassessed.

An alternative approach to suicide prevention contracts, which has been proposed by Miller,<sup>4</sup> relies on the basic te-

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nets of informed consent. The process of informing patients at risk for suicide about treatment and management is used to assess their ability to develop and maintain a therapeutic alliance.

### Legal Issues

A question often raised by clinicians who use suicide prevention contracts is, "What legal authority do these agreements have, if any?" Will a written or oral agreement with a patient not to commit suicide immunize the therapist from a lawsuit if the patient subsequently attempts or commits suicide? A clinician's presumed defense of "breach of contract" is not likely to be sustained for the following clinicolegal reasons:

1. *The parties to the contract must be legally competent parties.* A person must have sufficient cognitive capacity—or ability to understand the nature and consequences of a proposed transaction—to be considered competent to make a contract.<sup>6</sup> A contract is voidable when the party "by reason of mental illness or defect. . . is unable to act in a reasonable manner in relation to the transaction and the other party has reason to know of this condition".<sup>7</sup>

A legal presumption exists that all adults are competent. With the patient who is mentally ill and suicidal, however, serious questions would likely arise regarding the legal competency of the patient to enter into an agreement, such as a suicide prevention contract, with the clinician. Medication effects and transference phenomena in an already mentally compromised individual could undermine any conclusion that a patient was suffi-

ciently competent to contract.<sup>8-10</sup> A severely depressed or agitated patient may be functionally incompetent (affectively incompetent), thus lacking the mental capacity to enter into any type of contract.<sup>11</sup>

2. *The agreement or contract must include a valuable consideration—an inducement for each party to carry out his or her part of the bargain.* Money is a valuable consideration. The fee paid to the practitioner is in exchange for the promise to provide competent professional services to the patient. In agreeing to a suicide prevention contract, no additional consideration is provided by the patient.

3. *A mutual obligation must be imposed on each party.* In a suicide prevention contract, the patient is the only party actually agreeing to forbear or not do something that he or she is under no legal obligation to give up. The patient "contracts" not to attempt suicide or to call the clinician if he or she feels suicidal. However, the patient has no contractual obligation beyond payment for professional services received. The clinician's promise to be available for the patient is an extension of the legal duty of care that is already owed the patient. Therefore, from a legal perspective, the clinician's duty stated in a suicide prevention agreement is superfluous. Further, the fiduciary nature of the clinician-patient relationship, where the clinician holds a significant power advantage over the patient, would likely nullify the legal validity of a suicide prevention contract between the parties.

4. *The contract must not contravene public policy.*<sup>12</sup> A suicide prevention con-

tract is a classic example of an "exculpatory clause."<sup>13-15</sup> Persons may not enforce contract terms that would relieve them from liability for any harm caused by their negligence. Therefore, a suicide prevention contract with a patient would not immunize a clinician from legal liability if the clinician's conduct was negligent and proximately caused the patient's death or injury by suicide. Clinicians cannot contract to provide less care than what is normally owed, regardless of whether a patient implicitly or explicitly agrees to the arrangement. To do so would violate public policy. Negligence is not something that can be "contracted" away.

Also, although suicide is no longer a crime in any state, suicide itself is against public policy.<sup>16, 17</sup> Therefore, a contract written to prevent an act that already has been declared to be against public policy is a meaningless contract.

In *Stepakoff v. Kantar*,<sup>18</sup> the psychiatrist thought he had a "solid pact" with a manic-depressive patient to contact him if the patient felt suicidal. The patient did contact the psychiatrist or his designated replacement on several occasions. After a favorable telephone assessment of the patient's mental stability and the patient's defense mechanisms, the psychiatrist felt that the patient was unlikely to commit suicide. However, the patient did commit suicide. The Massachusetts Supreme Judicial Court found for the psychiatrist by affirming that the psychiatrist's legal obligation to the patient was to treat him according to the standard of care and skill of the average psychiatrist. Having a "solid pact" with the patient against suicide fell within such a standard. However, the

Court did not express an opinion about suicide prevention pacts.

Courts seem unlikely to give much credence to a suicide prevention contract if deviation in the standard of care is present and the patient attempts or commits suicide. In *Stepakoff*,<sup>18</sup> the psychiatrist was able to demonstrate that he provided clinically appropriate care and procedures through frequent contact and assessment of the patient. In addition, the psychiatrist documented his consideration of involuntary hospitalization. He also used an "active" substitute therapist while he was on vacation.

Clinicians who defensively consider "no harm" contracts to be valid legal instruments that bind the patient not to commit suicide make a twofold error. First, the belief that a legal document could prevent a patient from committing suicide is naive and self-delusive. Clinicians who are under considerable pressure in managing difficult suicidal patients may regressively grasp at the belief that signing a document binds the patient not to commit suicide. Thus, obtaining a contract against suicide from the patient can become a magical ritual designed to fend off the clinician's anxieties. Second, producing a suicide prevention contract in court signed by a deceased patient will not immunize the clinician against legal liability. On the contrary, unless the clinician performed an adequate assessment of suicide risk and made adequate risk-benefit assessments prior to his or her clinical decisions, the contract against suicide could indict the clinician who relies solely upon it to prevent a patient's suicide.<sup>19</sup> The inappropriate reliance on

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“contracts for safety” to the exclusion of competent evaluation and suicide risk assessment by a qualified clinician possessing sufficient information to make the assessment creates a high risk of legal liability.<sup>20</sup>

### Risk Management

Merely asking patients whether they are suicidal and obtaining “no harm” contracts are, by themselves, insufficient measures. A layperson can just as easily ask these same questions. Formal suicide risk assessment is the best risk management. The clinician must obtain an adequate psychiatric history and document competent suicide risk assessments that inform appropriate clinical interventions.<sup>21</sup> Unfortunately, the contract against suicide tends to be a specific event, whereas suicide risk assessment is a continuing process. The therapeutic alliance may seem firm during the session but can fluctuate between sessions or even dissipate. One way in which the contract can become part of an effective assessment process is to review at appropriate intervals the patient’s willingness and ability to call the clinician or to notify the hospital staff if she or he is experiencing suicidal thoughts.

The contract against suicide can be a useful clinical risk management strategy when it facilitates good clinical care. For example, some patients may be reassured by the clinician’s stated interest and availability. The therapeutic alliance may be strengthened thereby and the suicide threat lessened. Sound risk management is always a derivative of good clinical care. The suicide prevention contract, by

itself, merely creates an illusion of safety when it is not combined with competent treatment and management of the patient.

Suicide prevention contracts may be used to assess the competence of patients to collaborate with treatment and management decisions. The ability to reach out to another person for help in a time of crisis indicates the presence of a basic level of adaptive trust and competence. Patients with acute psychotic and affective disorders may not possess the collaborative capacity to enter into a behavioral contract. Patients with personality disorders usually possess the mental capacity to collaborate with psychiatric treatment. However, because of maladaptive character structures and psychological defenses, the patient’s ability to collaborate in a suicide prevention contract may be impaired. Gutheil<sup>22</sup> recommends that clinicians should carefully evaluate their patients’ competence to participate in clinical decisions. Suicidal patients who are not competent to cooperate with the clinician generally require more conservative management.

### Conclusion

The suicide prevention contract may provide a “biopsy” of the therapeutic alliance. However, based on the nature and course of the patient’s illness, the therapeutic alliance can change rapidly. The biopsy is a single event that cannot substitute for the continuing process of suicide risk assessment. In the managed care setting, a high volume of patients and the short lengths of treatment may further inhibit the development of the therapeutic alliance between therapist and patient that

is so essential to good clinical care. The suicide prevention contract should not be relied upon to the exclusion of formal suicide risk assessment and thorough clinical evaluation of the patient.

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