Practitioner Forum

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I Feel Safe Here

Discharging the Undischargeable Patient

"If I go back out there, I'm going to kill myself or somebody else."
"I need help—I can't do it by myself—I need a program."
"I can't stay in a shelter. You don't know what those places are like."
"That program is no good. The staff over there doesn't understand my needs."
"My problem isn't substance abuse—I'm just self-medicating. What I need is psychological treatment."

If these phrases sound familiar, it's because you're acquainted with a subset of patients—seasoned patients—who have a menu of reasons with which to convince practitioners of their need for hospitalization. They return to treatment units on a regular basis, often because of drug and alcohol use. Many are homeless, having been evicted recently from their residence or somebody else's. The goal of these patients is to be admitted to an inpatient treatment unit and then, once admitted, to avoid discharge. "I feel safe here" becomes their mantra—even after their condition has stabilized.

Such patients represent a double-edged sword for psychiatrists and their treatment team colleagues, who are faced with the conundrum of differentiating an inappropriate (or inappropriately extended) admission from the irresponsible release of a potentially suicidal or homicidal patient.[1] To help clinicians in making these critical distinctions, I am suggesting a set of rules and responses to use when confronting this type of patient (Table). These practices were designed not only to allow for safer and timelier discharges, but also to help patients change their self-defeating behavior patterns.

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RULE 1: IF A PATIENT INSISTS THAT HE IS SUICIDAL OR HOMICIDAL, ADMIT HIM

You may have heard a patient say, "If I go back out there, I'm going to kill myself or somebody else," only to see those feelings seem to vaporize upon admission. You later observe the patient socializing leisurely and requesting privileges.

Some psychiatrists make the mistake of confronting such a patient by questioning the legitimacy of his suicidal threats, or accusing him of abusing the system.[2] Patients may view that accusation as a challenge and respond by attempting suicide to prove that they are, in fact, suicidal. Besides failing to help the patient identify and overcome problems, this scenario diminishes the psychiatric profession in the eyes of our colleagues and the public. Worst of all, a patient can misjudge the lethality of his or her actions and accidentally succeed in committing suicide.[3]

Although it may seem that Rule 1 capitulates to the patient's demands and, thereby, reinforces a pathological pattern, it does allow the clinician to avoid extended admissions and effect timely discharges, while providing suitable and effective treatment. And it does so through the enforced relationship between privileges and progress toward discharge.

Patients are often given off-unit privileges and off-grounds passes from psychiatric units to allow staff to assess the patients' ability to function on their own outside the treatment facility. Passes also allow patients to arrange for postdischarge placement and aftercare. Some facilities, however, leave room for self-defeating patients to manipulate the system,[4] as the following scenario illustrates.

A patient enters the emergency department, intoxicated and claiming to be suicidal and homicidal. When asked about a suicide plan, he says that he will overdose on drugs, step in front of traffic, or perform a similar self-destructive act. When questioned about a homicide plan, he says that he will kill the first person he runs into. After receiving medical clearance, he is admitted to the psychiatric unit and placed under observation.[5]

Upon admission to the psychiatric unit, the patient says he is no longer suicidal or homicidal and requests permission to dress and receive privileges. He is granted off-unit privileges, and before too long, the treatment team cannot locate the patient for discharge planning because he is so frequently off the unit.

When the patient finally meets with the team, he requests passes to leave the facility to look for housing, and is granted permission. Eventually, he arranges for housing, but says he is unable to make the required deposit until the first of the month. Discharge, therefore, is postponed until then. Finally, the patient is discharged and scheduled for outpatient follow-up. Soon after, the patient returns and the cycle repeats itself.

Often, this happens again and again with the same players—both patient and staff. It simply becomes too time-consuming and frustrating to negotiate

through an entrenched system, faced with grievances and threats ranging from suicide to malpractice. It's simply easier to readmit the patient and let the pattern repeat itself. This, of course, contributes to psychiatric provider burnout and crystallizes the patient's pathology.[6]

The self-defeating cycle can be avoided, however, if permission for off-unit and off-grounds passes is contingent upon the patient's progress toward discharge. A clear treatment plan should be articulated as soon as the patient is detoxified, medically stable, and competent. An initial discharge plan, including a tentative discharge date, should be set as a prerequisite to any privileges.

RULE 2: CONSIDER A "NO-RELAPSE CONTRACT"

Although no-relapse contracts provide no guarantee against legal liability, they can provide incentive for the patient to stay on task and avoid relapsing (Figure). Such contracts, however, are meaningful only if the patient is convinced of their worth.[7]

Patients who display a proclivity for cyclic readmission should be advised that they will no longer receive privileges or passes, and will be discharged when they are no longer suicidal or homicidal. Remaining on the unit in pajamas provides an aversion to feigning or exaggerating claims of suicidal ideation, while keeping the patient available for treatment.

Angering or goading the patient into requesting discharge is not the goal of a no-relapse contract. Every discharge plan should include an offer of outpatient treatment, but finding an outpatient treatment program can be as problematic as finding inpatient and residential programs. Although the 1990s saw a rise in the provision of timely addiction treatment, accessibility is still limited in programs that care for indigent patients.[8–10]

Table. Rules and responses to use when confronted with an undischargeable patient

No.	Rule	Response
1	Do not second-guess a suicidal patient, admit him or postpone his discharge	No street clothes, no privileges, no passes—we must keep you under observation for your own safety
2	For unavoidable off-grounds passes, have the patient sign a no-relapse contract	Do not relapse and come back expecting to be readmitted by claiming you are suicidal and homicidal
3	No cash for transportation	We'll get you a bus token, train ticket, or taxi voucher
4	Responsibility for getting well belongs to the patient	We've given you the best help available, why do you think it hasn't worked?
5	Help the patient put things in proper perspective	We're not sending you to live on the streets, we're sending you to a community shelter
6	Empathize, but challenge	We know it's not easy—but we have confidence in you
7	Break the cycle of the blame game	It's time to stop burning bridges and start rebuilding them
8	Be positive and sincere	Complete 30 days of outpatient treatment and we will support a referral to another inpatient or residential program
9	Substance abuse by any other name is still substance abuse	This isn't self-medication, it's self-destruction
10	No double-binding	You can't have it both ways—either you're suicidal or you are not

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RULE 3: DO NOT GIVE TRANSPORTATION MONEY TO PATIENTS PRONE TO RELAPSE

Although patients may receive such help as a bus token, train ticket, or taxi voucher, they should not be provided with cash. If this rule is not followed, a subset of patients will return to the emergency department—sometimes the very same night—intoxicated, presumably after using the transportation money to purchase alcohol.[11]

Many of the patients with substance abuse histories will tell practitioners, "I need help…I can't do it by myself…I need a program." Several of them have been through numerous substance abuse treatment programs. In fact, in an unpublished study designed to clarify the extent of serial enrollment in substance abuse treatment programs, I found that, of a cross section of veterans admitted to the Addictions Rehabilitation Unit of the North Chicago VA Medical Center, North Chicago, IL on June 27, 2005, 23 had a total of 300 prior admissions for detoxification or substance abuse rehabilitation. Of the 23, one had no previous substance abuse treatment, one had a single previous treatment in a private facility, and one had 89 previous admissions. Eliminating those three outliers, the remaining 20 had a total of 208 admissions among them, for an average of 10.4 admissions per patient for substance abuse treatment. The 119 admissions were for programs that ranged from 21 to 315 days.

The best way to address this issue is to review the patient's record with him. Show him the list of admissions and discharges he has accumulated over time. Point out the fact that you, your facility, and others have tried to help him many times—and it doesn't seem to have worked. What, you may ask him, are his thoughts about why these programs have not worked for him? Moreover, why does he think another program will work for him now?

No-Relapse Contract

1. I, _________________, understand that relapse of substance abuse often occurs when off-grounds passes are allowed while awaiting treatment, or before treatment has been completed.
2. I am requesting a pass even though I have been advised by my treatment providers of the strong risk of relapse.
3. I have been advised by my treatment providers that I should give my sobriety precedence over any off-grounds business.
4. In view of the above information, I agree that I shall not relapse to illicit drug or alcohol use of any kind, and shall return to my unit as scheduled.

If I should relapse:

5. I understand that no excuses will be offered or accepted.
6. I shall not expect to be readmitted to this facility except for treatment that a physician determines to be medically necessary.
7. I shall not make claims of being suicidal or homicidal in order to be readmitted.
8. I shall not expect that any treatment plans that were in place prior to my relapse will still be in force.
9. In order to reinstate any previous treatment plans, I agree to complete at least 30 days of documented outpatient treatment.
10. I shall reside in a community shelter, if necessary, while attending the required outpatient treatment program.

____

Patient Signature

Figure. Proposed text for a no-relapse contract, which is intended to be signed by patients who fear discharge.

RULE 4: GIVE THE RESPONSIBILITY BACK TO THE PATIENT

Remind the patient that he has been through many programs and has had the best help available to him. Explain that he can participate in program after program, but none can make him sober if he chooses to relapse. He can fall into a bottomless pit of programming, climbing out into the real world only for short periods of time, until he feels safe only in a program. It's important for the patient to understand that only he can complete the picture of sobriety.

If, in spite of this counseling, the patient insists that he needs to go through yet another program, he should take on the responsibility of implementation. For example, explain that, "Since you just left a program, we recommend you try outpatient treatment now. You're welcome to apply to an inpatient program, but we cannot support it. It will be a self-referral. We will help you with transportation to a nearby shelter while you apply."

To this, the patient will likely reply, "I can't stay in a shelter. You don't know what those places are like."

The ideal rebuttal is to tell the patient that you certainly do know what the shelter is like—because you have taken a tour of it (and be sure to do so, so you have a point of refer-

ence). If you have no personal knowledge of the local shelters, it's important to help the patient see that almost any shelter is an acceptable alternative to living on the street.

RULE 5: PUT THINGS IN PROPER PERSPECTIVE

To make this point with the patient, compare shelter living to other, less desirable living situations in which the patient has found himself. You can point out that if he's ever stayed in a bivouac during the Vietnam War, lived in a crack house, or spent time in jail he certainly will be able to handle living in a shelter. As a final argument, the patient may tell you that "all shelters are just like crack houses…they are full of users, drugs, and alcohol…I'll surely relapse if I go there…." While there may be some truth to that statement, it's important to acknowledge that this isn't true of all shelters[12] and that waiting for a substance abuse program is not an acceptable excuse for extending the inpatient admission.[13]

RULE 6: EMPATHIZE, BUT CHALLENGE

It is also useful to challenge the patient to show his motivation for rehabilitation by staying at a shelter until a program bed is available. For example, you can say, "If you don't have enough motivation—after all this treatment, after all you've been through—to stay in a shelter for a short period of time, then you're not ready to change your lifestyle and get clean and sober once and for all." Then, be sure to follow up with a firm statement of encouragement, such as, "We're not saying it's easy. But you have to do it. We think you can do it. We have confidence in you. Show yourself you can do it."

RULE 7: BREAK THE CYCLE OF THE BLAME GAME

In some cases, a patient is discharged from a substance abuse program because he was inadequately assessed for admission in the first place and only later did it become apparent that there were psychiatric or other factors that made the program a poor match for his needs.[14] More often, however, a patient is asked to leave a program after having committed a lengthy list of infractions—both major and minor—with a sequence of unfulfilled requirements and ineffective consequences, culminating in the staff's decision to discharge him.

The patient will likely explain away the discharge by telling you, "That program is no good…The staff over there doesn't understand my needs." In such cases, it is not a good idea to use the tactic noted previously—that is, to tell the patient to make his own self-referral to another program. The last thing you want to do is to perpetuate the blame game and endorse the patient's inclination to jump from one program into another.

Instead, if possible, review the progress notes written by the program staff. If no progress notes are readily available, call the program and see if someone can give you information about the patient. It's important to understand what went wrong in order to avoid making the same mistakes.

With patients who were discharged for cause, some reasonable confrontation is indicated. "From the record," you might tell the patient, "it looks like you frequently slept in, missed meetings, failed to turn in writing assignments, went off station without a pass, and borrowed money from other patients." Avoid repeating judgmental comments such as, uncooperative, arrogant, not a team player, disrespectful, and unmotivated, because those are subjective in nature and will incite an argument. Instead, focus on concrete infractions. Review the facts with the patient, and help him place the blame for his problems where it belongs. Then you might explain to the patient that he is burning his bridges with respect to substance abuse treatment programs, and it is his responsibility to rebuild his reputation. At this point you can offer him options for helping himself.

There is a useful approach that moves the patient toward a timely discharge. He can be offered help with getting into a new program, but only if he will show strong, sincere motivation by attending 30 to 60 days of outpatient treatment while staying in a shelter. He may attend any facility for outpatient treatment, as long as it is documented that he attended as recommended by the facility. The patient often will protest that he cannot possibly accomplish that and will fall back on all of his previous excuses. That is why it is important to be strongly encouraging.

RULE 8: BE POSITIVE AND SINCERE

Speak to the patient in a direct manner: "I could not in good conscience refer you to another program at this point in time. I do not feel that would be helpful for you. It would be like jumping from the frying pan into the fire. I believe you can complete 30 to 60 days of outpatient treatment and, if you do, I will get you into an appropriate inpatient or residential program, if you still feel you need one." The last statement obviates the patient's objection that he is not being offered treatment: Although he is not being offered the treatment he prefers, he is being offered treatment.

In the cases in which a patient does follow through and enroll in an outpatient treatment program and has documented attendance for a month or more, it may provide you with a strong incentive to support him and look for an appropriate inpatient or residential program if, following outpatient treatment, he still desires and feels he needs that. Moreover, it is personally satisfy-

ing and professionally rewarding to have helped a patient accomplish this first big step. You may find that you really are enthusiastic about helping him further.

When patients do not follow through, however, they are unlikely to return requesting readmission to your facility as soon as they had in the past.

RULE 9: SUBSTANCE ABUSE BY ANY OTHER NAME IS STILL SUBSTANCE ABUSE

It's fairly common for a patient to claim, "My problem isn't substance abuse…I'm just self-medicating…What I need is psychological treatment." The response to this should always be, "This isn't self-medication. It's self-destruction."

"Self-medication" may be the most misapplied term in substance abuse treatment. Lammertink and colleagues found that the differences in lifetime consumption patterns between patients with comorbid psychiatric disorders and substance abusers without such disorders do not support the so-called self-medication hypothesis.[15] Further, Goswami and colleagues concluded that, "In spite of having been formulated nearly two decades back, there is as yet no consensus on the validity of the clinically popular self-medication hypothesis of substance use disorders in patients with dual diagnosis."[16]

Some patients believe—and would like to convince treatment teams—that they need long-term, psychological treatment before they can ever overcome their substance abuse. Although people with addictions may have other problems besides addiction that require both psychiatric and psychological treatment, substance abuse muddies the water and impedes the clear thinking required to resolve these other problems. Providers should emphasize that the patient must first eliminate the substance abuse and, only then, will their other problems—psychological, physical, and situational—come into clear focus so that they can begin to work through them.

RULE 10: EDUCATE THE PATIENT ABOUT DOUBLE-BINDING

When a patient tells you, "I feel safe here," this invocation double-binds the physician, eliminating both the option to discharge a patient whose condition is stable and the grounds on which to deny him privileges. After claiming to be suicidal and homicidal in the emergency room, the patient asks to be taken off suicide watch, allowed to dress, and given privileges and passes into town to "take care of business" once he is admitted to the psychiatry unit. In the most unabashed cases, these requests are put forth immediately after admission to the unit. The patient justifies this apparent turnabout by explaining that he will feel suicidal or homicidal again if he is discharged, but not if he stays in the hospital. He usually explains that, "Just knowing I am here and have all the staff around to help me, I'll be okay…."

Be cautious about confronting this type of patient too abruptly. Although he may ask to be taken off suicide observation soon after admission—which also serves to reduce the burden of the nursing staff—it is counterproductive to do so. Instead, advise the patient that good medical care dictates that he be observed for at least 24 to 48 hours. That will serve to notify him that the revolving door to inpatient treatment can no longer be taken for granted and that the course of his current and future admissions will be different.

When the patient offers firm assurances that he is no longer suicidal, discharge planning should be initiated in earnest. A patient whose primary goal is to remain in the hospital will insist that he will become suicidal again if you discharge him. He may use words and phrases designed to invoke feelings of guilt in his providers. He may say, for example, "You're going to throw me out on the street? Are the homeless and poor garbage to you? I'll kill myself if you send me out there!"

Inform the patient that you do care about him, you do not want anything bad to happen to him, and you will do everything you can to help him. Tell him that your plan is to keep him safe and secure, so he must remain on suicidal observation. He may protest that he does not need to be observed, because, after all, he "feels safe here."

A patient whose primary goal is to remain in the hospital will insist that he will become suicidal again if you discharge him.

But before the patient can embark on an effective treatment plan, he needs to come to terms with his own self-defeating behavior.

Explain to the patient that he cannot have it both ways and that whether or not he's suicidal does not depend on whether or not he's admitted to the hospital. If he does have suicidal thoughts, he must be kept under observation. Emphasize that this is for his safety—because the treatment team does care about him. If he concludes that he's not suicidal, then explain that you must discuss discharge and follow-up treatment with him.

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Patients may need time to mull over their options. Some may stand firm, insisting they will commit suicide if discharged. Occasionally, it is a case of bona fide malingering—marking time until a check is due to arrive, or avoiding the consequences of illegal activities. In any case, as long as the patient insists that he will become suicidal or homicidal if discharged, he should remain under observation, in pajamas, with no privileges or passes.

When confronting a patient who is competent but uncooperative—whether due to malingering, oppositional personality, or other issues—it is helpful to have the entire treatment team present. Meeting providers individually invites staff splitting—that is, it enables the patient to pit one staff member against another. Facing the whole team at once tends to thwart any such attempts on the part of the patient. It is important that the team plan the discussion together, in advance of the meeting, to ensure that they convey a clear, unambiguous message.[17]

Although it is onerous to the often short-handed nursing staff to keep a patient on suicide observation for an extended period of time, it does serve to reduce unproductive, revolving-door admissions, ultimately easing the burden on the entire staff. Of course, the nursing staff should always be included in the team planning.

Keeping patients under extended observation also helps them to review, and hopefully to see more clearly, their own counterproductive behavior patterns. Ultimately, though, this will happen only if all of the physicians who admit patients to the unit and all members of the treatment teams agree upon and follow a consistent strategy. ●

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