anxiety increased immediately following the smoking restriction, but not two years later.

The increase in verbal disruption and application of p.r.n. medications immediately after implementation of the ban may reflect greater anxiety due to sudden cigarette deprivation. The possibility that some patients were upset about having their smoking privileges suspended during hospitalization is supported by the finding of no increase in these incidents during the follow-up period two years after the ban. It is unclear why soft restraints were applied more often two years after the ban. The no-smoking policy may be unrelated to this finding, because no difference in use of soft restraints was observed immediately after the ban was imposed.

These results should be viewed in light of two limitations: the lack of a control group and possible cohort effects. In addition, generalizability of the findings may be limited to patients in inner-city teaching hospitals.

Hospital staff can expect minor increases in verbal outbursts after implementing a smoking ban. To minimize these disruptions, we recommend the staff be prepared for this change through education about nicotine withdrawal; that angry patients be redirected, for example by involvement in ward activities or one-to-one discussions; and that patients be provided with alternative sources of nicotine. Education to help staff differentiate nicotine craving from psychiatric symptoms is also suggested.

Conclusions
The study results show that dangerous behavior did not follow implementation of a smoking ban in a locked inpatient psychiatric service. Minor difficulties, such as increased verbal outbursts, did occur, but they were not disruptive to the hospital milieu. The findings suggest that even acutely disturbed psychiatric inpatients can tolerate abstinence from cigarettes.

References

Characteristics and Six-Month Outcome of Patients Who Use Suicide Threats to Seek Hospital Admission

Michael T. Lambert, M.D.
Johnnie Bonner, M.S., R.N.

Retrospective review of patients’ charts and other records was used to collect data on diagnoses, psychosocial characteristics, and subsequent suicide attempts of 45 patients who made contingent suicide threats, defined as threatened suicide or exaggerated suicidality reported to increase the likelihood of hospital admission, and 92 suicidal patients who did not make such threats. Patients who made contingent suicide threats were more likely to be substance dependent, antisocial, homeless, unmarried, and in legal difficulty. Subsequent suicide attempts were uncommon in both groups. The authors suggest that hospitalization should not be used as a substitute for social services, substance abuse treatment, and legal assistance for patients who make contingent suicide threats. (Psychiatric Services 47:871–873, 1996)

As mental health care systems de-emphasize costly inpatient treatment, admission decisions must be based on convincing evidence that hospitalization is appropriate. Suici-
Table 1
Clinical and demographic characteristics of suicidal patients evaluated in a psychiatric triage service, by whether patients made contingent suicide threats

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Contingent threats (N=45)</th>
<th>No contingent threats (N=92)</th>
<th>p1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance dependence</td>
<td>41</td>
<td>36</td>
<td>.004</td>
</tr>
<tr>
<td>Antisocial personality disorder</td>
<td>32</td>
<td>3</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Major depression</td>
<td>3</td>
<td>33</td>
<td>.003</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>3</td>
<td>4</td>
<td>n.s.</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>6</td>
<td>15</td>
<td>n.s.</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2</td>
<td>15</td>
<td>n.s.</td>
</tr>
<tr>
<td>Manic episode</td>
<td>2</td>
<td>0</td>
<td>n.s.</td>
</tr>
<tr>
<td>Other²</td>
<td>2</td>
<td>4</td>
<td>n.s.</td>
</tr>
<tr>
<td>Demographic characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active legal problems</td>
<td>18</td>
<td>15</td>
<td>.027</td>
</tr>
<tr>
<td>Homeless</td>
<td>34</td>
<td>27</td>
<td>.003</td>
</tr>
<tr>
<td>Currently married</td>
<td>3</td>
<td>27</td>
<td>.019</td>
</tr>
</tbody>
</table>

1 Fisher’s exact test, two-tailed
2 Includes dementia, panic disorder, other personality disorders

dality tops most checklists of admission criteria and is the justification for many actual admissions (1). Although hospitalization involves high costs and increases the risk of distracting attention from patients’ needs for long-term care, admission decisions are often based solely on the patient’s allegation that he or she is suicidal (2).

Suicidality frequently justifies psychiatric hospitalization, but claims of suicidality can be misused by patients who have a covert motivation for admission. Patients who need shelter or food or who want to escape from legal or interpersonal difficulties may report increased suicidality to avoid being denied admission or may threaten to commit suicide if not admitted. Such contingent suicide threats involve an “if not . . . then” communication that links suicidal intent to denial of admission.

This study compared the demographic and clinical characteristics of two groups of suicidal patients who presented to a psychiatric triage service—one group who made contingent suicide threats and a second group who did not make such threats. We tested the hypothesis that poor social support, substance dependence, and sociopathy are common among patients who make contingent suicide threats.

**Methods**

Study subjects were patients who presented to the psychiatric triage service at the Dallas Veterans Affairs Medical Center. The service evaluates psychiatric emergency patients between the hours of 8 a.m. and 4 p.m. on weekdays. The staff of the triage service consists of a registered nurse, a physician assistant, and a psychiatrist on call.

We retrospectively examined the records of 1,381 psychiatric triage assessments done by the second author during a one-year period from September 1, 1993, to August 31, 1994. The assessments represented about 25 percent of the emergency evaluations made by the triage service during the period. Suicidality was the primary presenting issue in 137 cases. A contingent suicide threat was deemed to be present if the patient actively made statements or threats to kill himself or herself if hospital admission was denied or if the patient acknowledged, after admission, that he or she had exaggerated suicidality during the screening process. Using these criteria, a contingent suicide threat was judged to be present in 45 of the 137 cases. The remaining 92 cases constituted the noncontingent group.

Data on patients’ diagnoses and employment, marital, and legal status and on whether they were homeless were obtained from evaluation notes, chart records, and computerized summaries of data on discharge and on patients’ psychosocial characteristics. Subjects’ primary and comorbid diagnoses were made by clinicians using DSM-III-R criteria (3). Subjects were considered to have active legal problems if their records included documentation of charges pending, probation, or parole. Subjects were considered homeless if their records included evidence that they were living in a shelter or were at imminent risk of losing their current housing situation.

We reviewed charts and risk management data from the medical center to determine whether subjects had attempted suicide within the six months after the triage evaluation. Suicide attempts were defined as behavior intended to end one’s life. In addition, reports from the Dallas County medical examiner were screened to determine if any subjects had completed suicide within six months after the triage evaluation. Dallas County residents accounted for 129 of the 137 patients evaluated for suicidality (94 percent) during the study period.

**Results**

The 45 patients who made contingent suicide threats did not differ from the 92 suicidal patients who did not make such threats in age, gender, employment status, or likelihood of being admitted to the psychiatric inpatient service. The average age of the 137 patients was 44.5 years, 96 percent were male, and 85 percent were unemployed. After evaluation in the triage service, 30 of the 45 contingent patients (66.7 percent) and 73 of the 92 noncontingent patients (79.3 percent) were admitted to the inpatient service.

Table 1 shows selected diagnostic and demographic characteristics of the two groups. Patients who made contingent suicide threats were more likely to have an axis I diagnosis of substance dependence and an axis II

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Dr. Lambert is assistant chief, Psychiatry Service 116A, Dallas Veterans Affairs Medical Center, 4500 South Lancaster Avenue, Dallas, Texas 75216, and assistant professor at University of Texas Southwestern Medical School at Dallas. Ms. Bonner is a staff nurse at the Dallas VA Medical Center.
diagnosis of antisocial personality disorder. Patients in the noncontingent group were more likely to have a primary diagnosis of depression. There were no differences between the two groups in the frequency of other diagnoses, including schizophrenia, borderline personality disorder, posttraumatic stress disorder, manic episode, dementia, panic disorder, and other axis II disorders. The group who made contingent threats also had higher frequencies of active legal problems and homelessness and were more likely to be unmarried, compared with the noncontingent group.

During the six-month follow-up period, ten documented suicide attempts occurred among six members of the noncontingent group (6.5 percent), and two attempts occurred among two members of the contingent group (4.4 percent), a nonsignificant difference. One completed suicide occurred in the noncontingent group. The patient was an elderly depressed man who had been treated as an inpatient and discharged.

**Discussion**

Our study had several weaknesses reflecting those discussed by Fawcett and colleagues (4), including the retrospective design, the small number of patients examined, and the short follow-up period, which may not have been long enough to provide meaningful outcome data because suicide is rare in a six-month period even in high-risk populations. It is also possible that clinicians in our study setting overdiagnosed substance abuse and sociopathy among patients they perceived to be manipulative. In addition, patient populations in which substance abuse and antisocial personality disorder are common often have other characteristics that are inherent in the concept of contingent suicidality, including being exploitive and manipulative and seeking secondary gain. Due to these weaknesses, our conclusions are tentative. However, the results raise several issues.

Persons who lack social supports may exaggerate claims of suicidality during the admission process in order to obtain shelter and food or to avoid legal or social difficulties. This view is supported by our findings, in which homelessness, lack of marital support, and legal problems were more common among the group who made contingent suicide threats.

Substance-dependent patients who are treated in settings affiliated with the medical center where the study was done occasionally use insincere suicide threats to obtain psychiatric hospitalization. Patients may try this strategy after they have exhausted their funds on drugs or when they have trouble with drug dealers or the police. These patients seldom follow up with addiction recovery aftercare. We have observed that, over time, repetitive psychiatric hospitalization actually facilitates addiction for some patients by providing temporary refuge from drug-related psychosocial problems. The higher percentages of patients with substance dependence and antisocial personality disorder in the contingent group supports these observations.

Traditional suicide risk factors are relatively static and often unalterable. They include the nature and number of previous suicide attempts; psychiatric diagnoses, such as depression, schizophrenia, substance abuse, and personality disorder; medical illness; older age; male gender; and poor social support (5,6). These factors predict risk over the long term rather than the immediate time frame of the admission decision process. Psychiatrists rank hopelessness as the most serious indicator of immediate suicide risk (7). It is possible to conceptualize the investment in the self and the future entailed in a contingent suicide threat as a sign of hope.

Psychiatric hospitalization has little documented effect on long-term suicide risk and is expensive, stigmatizing, and disruptive of social and occupational bonds. Not admitting a patient with stated suicidality raises clinicians’ anxiety about the medical and legal consequences of their decision. A minority of patients exploit this fear, essentially forcing clinicians to take “calculated risks” if they do not admit the patient (8).

However, using psychiatric hospitalization to address structural problems such as homelessness and legal difficulties is clearly inappropriate and costly. In addition, for certain patients, episodic psychiatric hospitalization may substitute for more helpful outpatient interventions focusing on factors contributing to the risk of eventual suicide. From an ethical perspective, rigid adherence to traditional psychiatric protective beneficence may compromise the patient’s long-term welfare and undermine the development of the patient’s autonomy and responsibility (9).

**Conclusions**

In an overall assessment, information about whether the patient has made a contingent suicide threat may be useful to the clinician in making decisions about psychiatric admission and in providing appropriate care. Patients who make such threats may be better served by careful screening, crisis intervention, and redirection to appropriate outpatient services than by receiving carte blanche admission to inpatient care. Addiction treatment, social services, and legal support are also important interventions for these patients.

**References**