No-Suicide Contracts as a Suicide Prevention Strategy

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The role of no-suicide contracts is but a small tactical piece of the larger strategic approach to the assessment and prevention of suicide. Its many obvious limitations-to some degree in assessment, but primarily in suicide prevention-should have driven serious discussion of no-suicide contracts out of consideration as a practical measure in clinical practice and a legal talking point in the courtroom. Yet the construct, practice, and surrounding discussions of no-suicide contracts survive despite all their many weaknesses and seemingly terminal status. Why? What keeps them alive?

It may be that in the microcosm of suicide prevention, where all rational strategies and predictions dissolve before the impulsiveness, determination, cleverness, and persistence that are the hallmarks of seriously suicidal persons, and where the differentiation between the seriously and imminently suicidal person and the neurotically opportunistic parasuicidal person with hidden agenda is often impossible to divine, the no-suicide contract seems to offer an arena where personal connection and human relatedness make a difference. The no-suicide contract seems to hold the promise that the strength of a relationship of a particular patient to a particular clinician will make the critical difference in keeping a person from taking the final steps in a long chain of visualized and possibly rehearsed scenarios of self-destruction.

Paradoxically, clinicians, especially in those frequent situations in which a strong relationship with the suicidal patient does not exist, instead bank on a peculiar social assumption about human behavior that has its roots in childhood and possibly even in our genes, that promises, commitments, and contracts are binding on each individual even in the face of inconvenience, even when contrary to our strongest urges. It is as if "promises are to be kept" is the 11th commandment by which we guide our lives.

Limitations for suicide assessment

What are the limitations of the no-suicide contract? They are vast. If we first examine its use in suicide assessment, it is sometimes said that refusal to commit oneself to a no-suicide contract conveys to the clinician that the person is seriously contemplating suicide and does not want the moral encumbrance of a promise to act as a brake.1 The assumption is that the scruples of the person, however suicidal, would actually interfere with agreeing to a no-suicide contract. Such is the assumed power of keeping one's word, no matter what. Deception is worse than death.

Optimistically, refusal to agree to a no-suicide contract may be intended by the suicidal person as a communication of serious intent in order to give the clinician an opportunity to intervene. In such a case, the clinician would be insensitive and even negligent in not acting on this cue to safeguard the patient. This is the best that can be said about a no-suicide contract as an assessment tool. The problem is, as can readily be appreciated, that refusal to agree to a no-suicide contract can have many other meanings, centered around motives and personality styles of struggle, hostile or dependent engagement, victimization mentality, testing of a relationship, and the need to raise the stakes and create excitement in one's life. Reciprocally, agreement to a no-suicide contract may be a disingenuous attempt to avoid interference with one's serious suicidal intent. The upshot is that agreement with a no-suicide contract does not help in assessment of suicide and refusal of a no-suicide contract still leaves the clinician guessing about the meaning and importance of the refusal.

Furthermore, the attempt during an initial evaluation, especially in situations of high stress and preoccupation with suicide, to obtain a no-suicide promise from a patient whom one has just met has the strong potential to backfire because it lends itself to the perception that the clinician is more interested in legalistic self-protection than in understanding the patient's desperate situation. This again raises the question of whether the no-suicide contract has relevance and benefit only in situations in which some sort of therapeutic relationship already exists. The psychiatric literature is in agreement that a no-suicide contract, if it is employed, cannot substitute for

the careful and detailed assessment of suicide risk.2-5

Limitations for suicide prevention

In the arena of suicide prevention, the issues are muddier and more complex rather than simpler. First of all, characteristics of the patient under evaluation, the context and location of the interaction, and the nature of the relationship between patient and clinician are very important. It makes no sense to indiscriminately endorse no-suicide contracts generically as is often done at the time of admission to an inpatient unit. However, collaborating on an initial treatment plan by spelling out what the ideal expectations of patient and clinician are and communicating genuine concern for the patient at both a professional and personal level, even at a first meeting, needs to be distinguished from the formalistic procedure of extracting a promise to forswear suicidal and other self-injurious behaviors.

Some inpatient services include a no-suicide contract in the documents that a patient initials or signs on admission: laundry list, HIPAA confidentiality regulations, personal belongings put into storage, insurance information, smoking policy, and meal schedule. In effect, a tool that might be useful in a family setting in which there is an ongoing relationship with the patient is being used during a nursing evaluation and management of risk of the patient, in a setting in which the parties to the "contract" are essentially strangers to each other.

Given that the average length of inpatient stay has been reduced in the past few decades to 3 to 7 days and that criteria for admission have been constricted to imminent risk of suicide, homicide, or total failure of outpatient treatment programs, clinicians must safeguard and treat an increasingly high-risk, impulsive, often drug-addicted population with strategies that do not allow much development of a therapeutic relationship.

In a retrospective chart study, Drew6 found that patients who had no-suicide contracts were more likely to engage in self-harm, although it is possible that negotiation of a contract reflects staff assessment of high risk. Hospitalization is no longer a process that emphasizes daily involvement with a psychiatrist and a close working relationship with nursing staff. As a corollary, keeping suicidal patients safe on a ward requires well-defined algorithms and protocols for assessing suicidality and implementing whatever procedures, including increased nursing time spent with a patient, are required, with no place for perfunctorily signed no-suicide contracts.7

In an outpatient situation, all the standard limitations of no-suicide contracts apply. Investigators agree that there is no empirical evidence that use of these contracts reduces risk of suicide; there are few studies and no controlled studies. In response to hearing about a clinical psychologist who was censured by the Minnesota Board of Psychology for not obtaining a no-suicide contract with a borderline patient who threatened but did not make a suicide attempt, and curious about the psychology board's rationale for this disciplinary action, I undertook a postcard survey of 514 psychiatrists in Minnesota inquiring about no-suicide contract practices.8

Of the 267 respondents, 152 (57%) used no-suicide contracts. Within this group, 62 (41%) psychiatrists reported that they had patients who had committed suicide or made a serious attempt after entering into a no-suicide contract. There was an inverse relationship between the use of no-suicide contracts and years out of residency training. The reason more experienced psychiatrists are less likely to use no-suicide contracts are not entirely clear, but it may in part relate to the seasoned judgement that if a therapeutic relationship is already present, then a formal contract has no moral claim on a patient. It may also be that psychiatrists recently out of training are more accustomed to using formal assessment instruments and legalistic forms than are older practitioners. Although experienced psychiatrists used no-suicide contracts less frequently, a higher percentage of experienced psychiatrists reported serious or completed suicide attempts in their practices. It is assumed that this finding reflects the greater number of years at risk for having suicidal patients in one's practice.

There were 2 goals to this study. The first was to inquire whether there was a standard of care among psychiatric practitioners about the use of no-suicide contracts. The answer was clearly no; slightly more than half of the respondents used it. The second goal was to obtain a rough measure of the effectiveness of no-suicide contracts. The limitations of the study are many, including lack of a control group, self-reported data, and sample bias in who responds to a postcard survey. Nevertheless, it is clear that no-suicide contracts are of little assistance, on average, in preventing serious suicidal behavior; although, there undoubtedly are cases in which a no-suicide contract as part of a richer therapeutic relationship between patient and clinician is effective.

There are situations in which rote adherence to a no-suicide contract policy interferes with effective treatment.9 The policy at a rural mental health program that operated a crisis hotline was that with suicide calls, the telephone counselor could not disengage until a no-suicide contract or promise was extracted from the caller. A patient with borderline personality disorder (BPD) came to appreciate the opportunity this policy afforded and began telephoning the crisis line 3 or 4 evenings per week, keeping the counselor on the line for an hour or two before reluctantly agreeing to a no-suicide pledge. This patient had never posed a serious threat for suicidal behavior, but the policy, until modified, did not allow for common-sense contingencies, such as limiting the telephone calls to 10 minutes per evening, or scheduling the patient to call in each evening for a brief status report.

If we consider the diagnostic spectrum, it appears that no-suicide contracts, in and of themselves, are untrustworthy in patients with schizophrenia whose suicidality may be psychotically driven, with alcoholic patients who are impulse-driven and cognitively and conatively incompetent when intoxicated, and with patients who have BPD for whom requests for a promise are overladen with too many control, manipulation, and relationship issues. It is also likely that a no-suicide contract would have different meaning and usefulness to adolescent, middle-aged, and elderly patients, but this too is an unexplored arena.10

Is it time to dispense with the no-suicide contract?

Recently, writers on this topic have concluded that the no-suicide contract is a construct that has outlived its usefulness. It sets up the

clinician for a nasty court battle in cases of completed suicide and suicide attempts that result in serious injury to the patient and provides little or no advantage overall. In its place, most investigators advocate careful suicide assessment and documentation and a suicide prevention plan that is one piece of a larger therapeutic contract, however construed. The decision to have a formal contract versus an informal therapeutic understanding appears to have as much to do with the clinician's personality and theoretical approach as it does to an evidence-based decision.

Rudd and colleagues,11 working from a cognitive-behavioral model, have written an interesting piece criticizing the conceptual basis and practical use of no-suicide contracts. In its place, they advocate an individualized commitment-to-treatment statement that is drafted and handwritten by both patient and therapist. This statement encompasses many areas of commitment to a broadly conceived therapeutic relationship, including such housekeeping topics as attendance at sessions, setting goals, completing homework assignments, and voicing opinions honestly. Included in the commitment-to-treatment statement is a crisis response plan that again is tailored to a specific patient and, by agreement, is time-limited. If advisable, family members' roles are incorporated into the steps of the crisis plan for when self-management fails.

The notion of a broad commitment-to-treatment statement that includes a crisis response component makes much sense; however, it cannot be applied to all patients in an outpatient practice, nor would it fit in with different styles of psychiatric and psychological care. Although its virtues cannot be questioned, it may be too rational and too formal and not fit some psychiatrists' style of interaction with patients. Perhaps it is best suited for a cognitive-behavioral psychotherapy practice.

An alternative approach is to openly discuss suicide risk and available responses to suicidality, including many of the elements mentioned by Rudd and colleagues,11 and to convey to patients concern about their safety and survival without extracting a no-harm pledge from a patient. As stressed by most articles in the psychiatric literature on suicide prevention, it is imperative to document assessment of risk and the response options discussed with the patient. Lee and Bartlett12 present an extended discussion of suicide prevention without the use of a no-suicide contract that includes thorough assessment, creation of an appropriate management plan, involvement of family and significant others, consultation with other professionals, and implementation of a plan that assumes professional responsibility.12

It is hazardous to develop absolute dictums in psychiatric practice beyond the general understandings against exploitation of patients. Assuming that the therapist's intentions toward a patient are professionally benevolent, questions still remain about what is best for a particular patient in specific circumstances. In the absence of evidence-based practice guidelines-and most daily psychotherapeutic interactions fall into this category-it is impossible to say that a no-suicide contract should never be used. This modesty of imperatives keeps the notion of no-suicide contracts as one of the viable options that the clinician may consider in working with patients at risk for self-harm. There is no good statistical evidence that no-suicide contracts do more benefit than harm, but the possibility that such negotiations may be helpful for some clinicians in some situations precludes any absolute recommendation against their use.

Recent psychiatric literature on the topic advises against routine use of no-suicide contracts as a suicide assessment or prevention tool or as a method of providing some legal protection in the advent of suicide completion and serious attempts.2,4 This is especially the case when a no-suicide contract is expediently substituted for a careful assessment of risk and a thoughtful and collaborative development of a suicide prevention plan.

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