The Case Against No-Suicide Contracts: The Commitment to Treatment Statement as a Practice Alternative

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This article reviews the literature on the use of "no-suicide contracts" in clinical practice, including conceptual discussions, patient and clinician surveys, and a few empirical studies on clinical utility. Our primary conclusion is that no-suicide contracts suffer from a broad range of conceptual, practical, and empirical problems. Most significantly, they have no empirical support for their effectiveness in the clinical environment. The authors provide and illustrate the commitment to treatment statement as a practice alternative to the no-suicide contract. © 2005 Wiley Periodicals, Inc. J Clin Psychol: In Session 62: 243–251, 2006.

Keywords: suicide; no-suicide contracts; crisis response plan; crisis management

The first discussion of no-suicide contracts in clinical practice was in an article by Drye, Goulding, and Goulding (1973), but Ewalt (1967) most likely provided the earliest reference to the general idea. Ewalt (1967) provided a wonderfully specific set of recommendations about the process and content of the clinical exchange with suicidal patients, although it was not identified as a no-suicide contract. A number of other clinicians,

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JOURNAL OF CLINICAL PSYCHOLOGY: IN SESSION, Vol. 62(2), 243–251 (2006)
© 2006 Wiley Periodicals, Inc.
Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20227

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including Shneidman and Farberow (1957), have offered similar discussions about the process of negotiating with at-risk suicidal patients, although they also did not formally refer to establishing a no-suicide contract. Similarly, others have provided discussions of the more broadly defined "therapeutic contract" (e.g., Etchegoyen, 1991), articulating roles and obligations in the treatment exchange without specific reference to the no-suicide contract.

Drye and colleagues (1973) provided a simple and straightforward method allowing patients and clinicians to reach an agreement or a "decision" about their suicide risk, with clear implications for management and treatment. What is perhaps most striking about their article is the lack of a clear theoretical or empirical foundation to the recommendations. They provide ample anecdotal support in the form of a statement that in "over 600 cases" they never experienced a suicide, but the lack of theoretical rigor and scientific precision makes definitive statements about the utility of the instrument problematic. From a theoretical perspective, this early work does *not* make it clear whether no-suicide contracts are an administrative procedure or a clinical intervention driven by an identified conceptual model. Without question, though, their work was groundbreaking and founded on clinical wisdom and common sense.

What is troubling is that over the past three decades the state of the art in this area has not moved much beyond this original work. Despite the methodological and legal challenges, practitioners seek an empirically supported and clinically useful method to document agreements with suicidal patients, with respect to both treatment goals and practical steps to be taken during periods of acute crisis. In this article, we review the literature on no-suicide contracts and present a practice alternative to it in the form of the commitment to treatment statement.

What Is a No-Suicide Contract?

No-suicide contracts are discussed in the literature in a number of ways, including as no-harm contracts, suicide prevention contracts, no-suicide decisions, or safety agreements or contracts. This list is not exhaustive, but these are the most common terms discovered. Surprisingly, there does not appear to be any uniform definition of a no-suicide contract, although there clearly are common elements across all references. Nor does there appear to be any consensus as to whether such agreements must be written and/or verbal. More often than not, no-suicide contracts are used specifically with patients who report suicidal thoughts or behaviors, but in some instances they have been used with all patients in the form of a broader agreement about the general nature of treatment or care.

Simply stated, a *no-suicide contract* is an agreement between the patient and clinician in which patients agree not to harm themselves and/or to seek help when in a suicidal state and they believe they are unable to honor the commitment. Common elements in no-suicide contracts include the following:

- An explicit statement agreeing not to harm or kill oneself
- Specific details about the duration of the agreement
- A contingency plan if a crisis that would jeopardize the patient's ability to honor the agreement emerges
- The specific responsibilities of both patient and clinician (Drew, 2001; Rudd, Joiner, & Rajab, 2004)

A number of problems warrant further discussion. Miller (1999) discussed the problem with the term *contract*, aptly identifying the *hidden messages* embedded in the word,

noting that such language implies more concern for medicolegal aspects of practice than the clinical process. Such a contract may limit open and honest communication because patients *have* nothing additional to gain by signing a contract (p. 472) given that such language may result in the added burden of appearing to attempt to free the clinician from blame for any bad outcome in treatment. Miller (1999) makes a compelling argument, one that indicates the term *contract* should be removed. We agree entirely and offer an alternative shortly.

For those hesitant to remove the term, Webster's (1975) definition reminds us of the potentially pejorative nature of such language in the clinical context: *a binding agreement between two* or more parties. What is troubling about the definition is the word *binding*. The definition of *bind* is to confine, restrain, or restrict; to constrain with legal authority; to put under obligation (Webster's, 1975). Of course, no-suicide contracts have no legal authority and the perception of *confining, restraining, and restricting* patients' behaviors at a time when they are struggling for control can prove disastrous.

Perhaps most unsettling about no-suicide contracts in the literature is the lack of a standard definition, but a close second would be the failure to provide a clear theoretical or conceptual model that articulates whether the agreement is a clinical intervention or a simple administrative procedure A quick review of the common elements summarized indicates that the agreement is more than just an administrative procedure; it is a clinical intervention with several core goals that can be specifically stated and empirically tested. Consistently with their use during periods of crisis, such agreements hope to do the following:

1. Facilitate honest and productive communication between the patient and therapist about suicidality by making it clear what the expectations are of both the clinician and the patient in terms of how potentially life-threatening issues will be addressed in treatment, identifying steps to follow in accessing emergency services during a crisis, offering a statement of the clinical implications (e.g., more intensive care, monitoring, hospitalization) of periods during treatment characterized by heightened risk, and acknowledging the control and responsibility maintained by the patient.
2. Assist in establishing and maintaining a healthy therapeutic relationship and collaborative process by articulating the need for open and honest communication and identifying the roles and responsibilities of both clinician and patient in the treatment process in general.
3. Facilitate active involvement of the patient in the treatment process, including readily accessing emergency services when and if needed.

All three of these core elements need to be included in our conceptualization of these agreements. If conceptualized as an actual clinical intervention, the effectiveness can be studied and eventually determined. Similarly, such a conceptual scheme provides the clinician the opportunity to identify how the intervention fits within his or her theoretical orientation. Then, testable hypotheses can be identified, studies designed and implemented, and the state of the science in this area advanced.

For example, from our cognitive-behavioral orientation, we would hypothesize the following:

1. The intervention is wholly consistent with establishing and maintaining a collaborative treatment relationship by engaging the patient in specific and critical decisions about treatment content and process and related boundaries.

2. It is intended to reduce patient anxiety, agitation, dysphoria, and hopelessness by providing a specific and detailed plan that enhances the patient's understanding of the problem and general sense of *control* and deactivating what Rudd, Joiner, and Rajab (2004) have referred to as the *suicidal mode*.
3. It is intended to enhance the patient's commitment to the treatment process and living, rather than request that the patient essentially *give up* his or her right to commit suicide. In contrast to the notion of a contract, making a commitment to *living* rather than *not dying* sends a very different message to the patient about control and individual responsibility, both explicitly and implicitly. The focus is not on *restraining or restricting* rights, but on enhancing commitment to a treatment process, a process of recovery.
4. It is designed to facilitate increased and appropriate use of crisis services.
5. It is intended to save lives.

Do No-Suicide Contracts Work?

Despite more than a dozen studies on no-suicide contracts, few have targeted their effectiveness, and those that have are riddled with methodological limitations. Most studies have simply chronicled the frequency of use of no-suicide contracts, cutting across both inpatient and outpatient settings. The central finding is that the majority of inpatient facilities and outpatient practitioners working with high-risk patients use some form of no-suicide contract (Assey, 1985; Buelow & Range, 2001; Callahan, 1996; Drew, 1999, 2000, 2001; Farrow & O'Brien, 2003; Kroll, 2000; Range et al., 2002; Simon, 1999; Weiss, 2001). Additionally, these studies have found that such unproven instruments are used with the greatest frequency with the highest-risk patients.

A few studies have looked at the clinical utility of no-suicide contracts, but all face serious methodological problems. An evaluation of more than 600 calls to suicide prevention centers in Canada indicated that only 54% of verbal agreements were upheld (Mishara & Daigle, 1997). The findings have limited relevance for daily clinical practice; nor were adequate controls or comparisons used. Drew (2001) conducted a *retrospective review* of medical records to assess the presence or absence of a no-suicide contract and eventual outcome. Contrary to confirming the effectiveness of the intervention, she found that patients who had no-suicide contracts were more likely to engage in self-harm. Again, a central problem is the lack of adequate controls or comparison groups. Jones, O'Brien, and McMahon (1993) offered some evidence for the utility of no-suicide contracts with children, but again the study did not provide for adequate comparison groups and was not randomized. Kroll (2000) found that 41% of clinicians who used no-suicide contracts had patients who died by suicide or made very serious attempts while under contract. Kelly and Knudson (2000, p. 1120) reached a similar conclusion to that suggested here, stating that no empirical evidence supports the effectiveness of no-harm contracts in preventing suicide.

We believe that only if two conditions are met can we move clinical science in this area forward. First, a common definition is needed, one that removes the term *contract* and provides a broader construct. Second, the conceptual model needs to view such agreements as clinical interventions, part of the broader treatment that fits within the full range of theoretical orientations. If these two conditions are met, then we can identify and articulate testable hypotheses and generate an empirical foundation that addresses the effectiveness of such agreements.

The Commitment to Treatment Statement

To satisfy these two conditions, we recommend the use of a commitment to treatment statement (CTS). It is defined as an agreement between the patient and clinician in which the patient agrees to make a commitment to the treatment process and living by (1) identifying the roles, obligations, and expectations of both the clinician and the patient in treatment; (2) communicating openly and honestly about all aspects of treatment including suicide; and (3) accessing identified emergency services during periods of crisis that might threaten the patient's ability to honor the agreement.

The CTS does not restrict the patient's rights with respect to the option of suicide; it does not specifically mention that the patient is removing the suicide option, only that the patient is making a *commitment to living* by engaging in treatment and accessing emergency services if needed. We believe both are critical to the effectiveness of such agreements early in the treatment process.

It is difficult to imagine that having known the patient for only a session or two, perhaps even the first time we have met, we would ask the patient to relinquish the right to self-determination, particularly if we have yet actually to provide anything concrete in the treatment exchange, such as symptom relief or the necessary skills for effective self-management. Perhaps one of the reasons that these agreements are more often violated than honored (e.g., Drew, 2001) is that the patient cannot make a meaningful commitment to remove suicide as an option *forever* during a period marked by intense psychological pain and before establishment of a meaningful therapeutic relationship. It is critical to acknowledge this dialectical tension, as Marsha Linehan (1993) has so aptly noted, rather than to attempt to *control it* through interventions that are yet to evidence any effectiveness.

Without question, *suicide as an option* will eventually have to be addressed in treatment. It is most appropriate to address the question after the therapeutic relationship has been firmly established, the patient has experienced some symptomatic relief, and the patient has developed adequate skills for self-management of crises (Rudd, Joiner, & Rajab, 2004). We have found it useful to help the patient articulate his or her *philosophy of living* at the midpoint in treatment. Suicide as an option naturally emerges as a part of this process and can be more clearly addressed.

CTS in Practice

We recommend that the CTS always be handwritten and individualized by the clinician; avoid using a standard preprinted form. The CTS should always include a crisis response plan, that is, the specific steps the patient should take during a crisis. Some manner of agreement should be accomplished in the first session. The implicit, and potentially problematic, messages are likely profound with use of a preprinted form. In addition to the central elements noted, it is important to identify any time restrictions imposed by the patient: What is the duration of the agreement—1 week, 1 month, 1 year?

Here is an example of a CTS from our practice (Rudd, Joiner, & Rajab, 2004):

I, _____, agree to make a commitment to the treatment process. I understand that this means that I have agreed to be actively involved in all aspects of treatment including:

(1) attending sessions (or letting my therapist know when I can't make it),
(2) setting goals,

(3) voicing my opinions, thoughts, and feelings honestly and openly with my therapist (whether they are negative or positive, but most importantly my negative feelings),
(4) being actively involved *during* sessions,
(5) completing homework assignments,
(6) taking my medications as prescribed,
(7) experimenting with new behaviors and new ways of doings things,
(8) and implementing my crisis response plan when needed (see the attached crisis response plan card for details).

I also understand and acknowledge that, to a large degree, a successful treatment outcome depends on the amount of energy and effort I make. If I feel like treatment is not working, I agree to discuss it with my therapist and attempt to come to a common understanding as to what the problems are and identify potential solutions. In short, *I agree to make a commitment to living*. This agreement will apply for the next three months, at which time it will be reviewed and modified.

Signed: _____
Date: _____
Witness: _____

As should be evident, this agreement is very different from the notion of an informed consent statement. It targets the patient's motivation and commitment to the treatment process, outlining core elements and expectations. The CTS can be as brief as this or more detailed, depending on the patient and the context.

As noted, the CTS provides a signature line for a "witness." More often than not the witness will be a significant other or family member involved in the treatment process. It has been frequently noted that the active involvement of family is important with high-risk patients, in terms of both accurate risk assessment as well as ongoing treatment and management (Rudd, Joiner, & Rajab, 2004). The CTS provides a mechanism to allow them to understand both the significant nature of risk and the resultant management plan. We would encourage clinicians to provide a copy of the CTS for the patient and encourage the patient to review and update the agreement as needed (e.g., when original time limitations are reached). A copy of the CTS should be kept in the file as it is an integral part of the treatment record. Along these lines, we would suggest it be treated as any other entry in the chart and forwarded to other providers if the clinical record is requested with a signed release. The CTS provides invaluable information on two fronts, including factors involved in the risk assessment process, risk categorization, and subsequent management decisions. Of particular importance, multiple versions of the CTS provide information about the progression of the treatment process, crisis management strategies, patient's compliance history, and resolution of critical issues about reasons for living and dying.

As referenced in the statement, a crisis response plan needs to be included. The crisis response plan (CRP) provides specific instructions for the patient on what to do during periods of crisis. We would suggest writing the steps on a 3 by 5 card or the back of a business card. In general, the first several steps in the CRP involve self-management, in an effort to build crisis management skills. The final few steps should include external intervention, including phone contact before accessing the emergency room. In order for CRPs to be effective, the clinician needs to be specific about what defines a crisis, particularly for individuals who have been chronically suicidal. It is also important to practice or role play the use of the CRP before implementing the agreement. The clinician may quickly discover that the plan assumes the presence of skills that are not yet adequately

developed. Finally, the CRP can be modified as treatment progresses, reflecting changes in skill level and need for external intervention.

The following is an example of a CRP for someone who has been chronically suicidal and thinks about suicide daily:

Crisis Response Plan

When I'm acting on my suicidal thoughts by trying to find a gun (or another method to kill myself), I agree to take the following steps:

Step 1. I will try to identify specifically what's upsetting me.

Step 2. Write out and review more reasonable responses to my suicidal thoughts, including thoughts about myself, others, and the future.

Step 3. Review all the conclusions I've come to about these thoughts in the past in my treatment log. For example, that the sexual abuse wasn't my fault and I don't have anything to feel ashamed of.

Step 4. Try and do the things that help me feel better for at least 30 minutes (listening to music, going to work out, calling my best friend).

Step 5. Repeat all of the above at least one more time.

Step 6. If the thoughts continue, get specific, and I find myself preparing to do something, I'll call the emergency call person at (phone number: XXXXXXX).

Step 7. If I still feel suicidal and don't feel like I can control my behavior, I'll go to the emergency room located at XXXXXXX, phone number; XXXXXXX.

It might be helpful to provide a brief example of how the CTS (and CRP) are introduced in the clinical exchange. What follows is a brief transcript about how to introduce the CTS.

THERAPIST: Since we've now discussed many of the problems that brought you here, including your thoughts about suicide, I'd like for us to come to some agreement about how treatment will work and what steps you'll take if another crisis emerges. How does that sound?

PATIENT: I'm not really sure what you mean?

THERAPIST: Well, I'd like to put down on paper what I like to call a commitment to treatment statement outlining what is expected of both you and me in treatment. For example, how often you'll be coming to treatment, how long the sessions will last, what we'll actually be doing when you're here, and what you'll do if you experience a crisis. The last item I call a crisis response plan. If OK, I'd like to write out the commitment to treatment statement on a sheet of paper and have both you and me sign it. I'll put the crisis response plan on the back of my business card so you can just put it in your wallet when you need it. I'd also like to have your wife sign the agreement since we'll be enlisting her help during treatment.

PATIENT: Actually I like the idea. I'd feel much better if I knew how things were going to work and what exactly I was supposed to do if I get in trouble and start thinking about killing myself again.

THERAPIST: As a part of this agreement, I'll be asking you to make a commitment to living; by that I mean that you're agreeing to being involved in treatment and accessing emergency services when needed. How long do you think you could make such a commitment right now? Could you agree to six months or longer?

PATIENT: I'd feel comfortable with three months right now.

THERAPIST: Then after three months we'll sit down and evaluate how things have gone and draft a new agreement at that time. I'm going to go ahead and start writing while we talk. One thing to remember is that this agreement can change if needed. All you need to do is let me know what things need to be modified. After we finish, I'll keep a copy and give one to you as well. OK, I'm making a note that this will last for three months and that we'll review at that time. Let's go through the things that will be involved in treatment.

Summary and Directions

We have reviewed the common elements and empirical literature on the complicated use of no-suicide contracts. We hope that the discussion clarifies the theoretical foundation and lays the groundwork for empirical work in the future. There is ample conceptual evidence that a CTS and CRP are clinical interventions embedded in and driven by theory. However, there is not yet any direct empirical evidence for their effectiveness.

The next step is to test the clinical utility of the agreements. Does a CTS differ from a no-suicide contract? Do patients who make and sign CTSs do better in treatment as indicated by compliance (e.g., session attendance, treatment participation, medication compliance) and symptomatic improvement (e.g., less depression, anxiety, hopelessness), report more satisfaction with treatment, and engage in less suicidal behavior? Do such patients access emergency care more frequently? Do patients who sign CTSs eventually eliminate the *suicide option* more frequently later in the treatment process? These are just a few of the questions that can be raised and tested. The next steps are clear; we need to provide a solid empirical foundation for the clinical utility of the commitment to treatment statement and the crisis response plan.

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