The Effects of the Use of “No-Suicide Contracts” in Community Crisis Situations: The Experience of Clinicians and Consumers

Tony L. Farrow, MHSc(Hons), RCpN
Alexander I. F. Simpson, BMedSc, MBCHB, FRANCP
Helen B. Warren, MA(Hons), RCpN

“No-suicide contracts” (NSCs) are commonly used in community crisis situations. Eight patients and nine nurses were interviewed to explore both how NSCs affect clinical outcomes and how suicidal persons experience their usage. The results suggest that suicide management decisions may be negatively affected and that some patients find the use of the tool to be unhelpful. While further research is needed, the results of this study suggest that careful consideration be given before NSCs are used in community crisis situations. [Brief Treatment and Crisis Intervention 3:241–246 (2002)]

KEY WORDS: no-suicide contracts, suicide assessment, suicide management, crisis intervention.

The “no-suicide contract” (NSC) is commonplace in many clinical situations, including suicidal crises in the community. Crisis clinicians who use NSCs generally request a promise from a patient to contact stated others (usually the crisis team) if he or she considers him or herself to be at imminent risk of suicide. Although the NSC is recommended by many authors, there is no published research on the usage of NSCs in the community crisis situation. This article describes the results of a qualitative study designed to address this absence by exploring the experiences of clinicians who formulate such NSCs, and of suicidal persons who have been subject to such usage.

Literature Review

Literature that either describes the historical development of NSCs or analyzes the tool has been well summarized elsewhere (e.g., Drew, 2001; Egan, 1997; Miller, 1999; Stanford, Goetz, & Bloom, 1994).

Most previous research into NSC usage has focussed on clinicians’ attitudes toward the tool and the prevalence of its usage (Davidson, Wagner, & Range, 1995; Drew, 1999; Green & Grindel, 1996; Kroll, 2000; Miller, Jacobs, & Gutheil, 1998; Mishara & Daigle, 1997).
Research focusing on the efficacy of NSCs at preventing suicidal behaviors has been undertaken with high school adolescents (Hennig, Crabtree, & Baum, 1998), psychiatric hospitalized adolescents (Jones & O’Brien, 1990; Jones, O’Brien, & McMahon, 1993), and adults in psychiatric inpatient units (Busch, Clark, Fawcett, & Kravitz, 1993; Drew, 2001). These studies offer inconsistent results, and because of various methodological limitations, require further research. No studies were found that either considered the effects of NSCs in community crisis situations, or examined adult patients’ opinions of the tool.

Methodology

Ethical approval for the research was gained from appropriate local ethics committees. To gain insight into the experience of the usage of NSCs, in-depth interviews with both clinicians who use NSCs, and patients who had recent experience (within the last 4 months) of being asked to agree to the terms of the tool, was needed. Registered nurses were the only clinicians interviewed from the former group, as they were most likely to be involved in initial crisis assessments with suicidal persons. Nine nurses were recruited after the first author described the proposed research at multidisciplinary team meetings at four community mental health centers. Any nurses who wished to participate were then able to contact the first author directly.

Patients who had been in a suicidal crisis and experienced a NSC, and were currently at low risk of suicide, were advised of the research by their community worker. Any patients interested in participating in the research were able to contact the first author directly. Eight patient participants were obtained in this manner. All fell within the mental health services “adult” category (18–65 years old).

Separate questions were asked of the patient and nurse interviewees, with all participants asked additional questions to either clarify or elaborate on their answers.

Questions asked of patients included: Can you tell me what a “no-suicide contract” or “contracting for safety” means to you? Can you tell me about the last time you were asked to enter into a NSC? What, for you, are the good things about NSCs? What, for you, are the less good things about NSCs?

Nurse participant questions included: What do the terms “no-suicide contract” and “contracting for safety” mean to you? Do you use NSCs in your practice? If so, why do you use them? What do you consider to be the good things about their usage? What do you consider to be the less good things about their usage? How do you think the use of NSCs affect management decisions for suicidal people?

Participants in both groups also had the opportunity to add comments outside the range of the formulated questions. All interviews were conducted face-to-face by the first author, and recorded for later transcribing. The first author undertook analysis of the transcribed interviews using Thomas’ (2000) general inductive approach. All transcripts were independently reviewed by one or both of the other authors, after which agreement was reached about the themes that emerged. These were then further discussed with a selection of participants (four nurses and four patients) to ensure that an accurate interpretation of the data had occurred.

Results

Effect on Decisions Relating to the Management of Suicidal Persons

Nurse interviewees described how the presence of the NSC forced more conservative dispersal decisions to take place—decisions that were not
considered to be warranted by the low level of suicidality that the patient presented with.

“Often people end up in hospital when not [a] serious [risk] because you feel trapped into conservative practices.”

In contrast, some nurses knew of situations where a management decision inconsistent with the high level of suicide risk had occurred because the patient had agreed to a NSC.

“The relationship break-up ones, ‘I’m going to kill myself if I can’t get back with my partner.’ It’s all very well to contract with them but they’re home alone [and] don’t have a lot of supports.”

**Diagnostic Information**

Six of the nurses considered the NSC offered diagnostic information about the level of suicide risk in patients. As one nurse summarized: “If a patient can agree [to contract], and their body language is congruent, then they are a low risk . . . if they can’t [contract] or their body language is incongruous, then there’s a problem [as they are deemed to be a higher risk of suicide].”

**Relationship Formulation**

All nurse interviewees indicated that NSCs were, on occasion, formulated with patients whom they knew. However this was not always the case. The crisis nurses often assessed suicidal people with whom no previous contact had been made. Nevertheless eight of the nurses considered that it was possible to formulate the NSC on the first meeting “as long as a relationship is evident.” Or, as another nurse put it: “If I’m asking someone to contract . . . I’m wanting to feel that they’re honest with me, that they’re trusting me, they’re sharing something that’s really very deep and personal—they’re prepared to give part of themselves and that’s got to be good because it’s establishing a rapport.”

**Empowerment**

Another prevalent theme throughout the interviews was the way in which the NSC affected issues of patient control and responsibility. Most nurses considered that the NSC was empowering to patients in a number of ways.

“They have some control of what is happening, and it’s about the fact that we can trust them—we are not going to pick them up and take them to hospital. There is some trust; they are taking responsibility.”

**Patients’ Experiences**

Rather than finding the NSC empowering, seven of the patient interviewees described the NSC as being disempowering. They felt that they were expected to be responsible for initiating further contact if the suicidal urges increased, meaning that they were solely responsible for their safety. All seven considered that refusal would have meant unwanted interventions, such as civil commitment. As one patient noted: “You know what’s going to happen if you say no . . . It’s like they pretend to give you a choice.”

Six patients described feeling that they were coerced into agreeing to the NSC.

“I think you just know just what is going to happen if you say ‘no,’ this is not what they want to hear, this is going to mean further trouble.”

“Contracting is intimidating and you are coerced into doing something.”

“[It] felt like they wanted me to sign on the dotted line. . . . I was forced into giving a cast-iron guarantee.”

Six of the patient group also had experienced the NSC formulation as detrimental to the relationship with crisis team members.

“I think there’s a feeling of vulnerability, of not being taken seriously enough, of feeling ‘what’s the point?’ and to do or say that over the phone is quite precarious.”
“It was like, ‘Who are these people?’ and ‘Why aren’t they listening to me?’”

“It [the introduction of the NSC] made them [the crisis team clinicians] seem very cold and just there to do their job and that is it. . . just ‘hurry up and get out of the way.’”

Five of the patients described having difficulty in openly expressing suicidal thoughts. They considered this to be of relevance when being asked to enter into an agreement placing the onus on them to call the crisis team when feeling this way.

“I guess I’m not very forthcoming in this situation with saying how I’m feeling or whatever, and it is important for them that I learn to do that.”

Discussion

This exploratory research has a number of limitations. First, the study has focused on clinicians and patients in one city in New Zealand. The transferability of the results is therefore not known. Second, it is possible that other clinicians who do not use the tool may have decided not to be interviewed. This omission may have deprived the research of valuable viewpoints. Third, the patient group included members who had been involved in only one crisis situation, as well as others who had been assessed for suicidality on a number of occasions. While all patients in the group had been assessed within the 4 months prior to the interview, it is possible that the number and frequency of crisis episodes might have a bearing on how those situations are experienced. Despite these limitations, we feel there are a number of important issues that emerge from these results.

In New Zealand, the hospitalization of a suicidal patient is primarily designed to establish effective therapeutic relationships with clinicians, institute treatment of mental illness, and in particular, to ensure the patient’s safety (Ministry of Health, 1993).

Determining the risk of suicide in an individual, and therefore whether or not to initiate hospitalization, requires clinical judgement that is not based on universal rules (Bongar, Maris, Berman, & Litman, 1992). Nevertheless, in New Zealand, minimum standards for the determination of the risk of suicide have been formulated (Ministry of Health, 1993). These standards are comprised of an assessment of the precipitating crisis, the history of the presenting problem, any relevant physical factors, any past psychiatric history, any alcohol and drug history, any family psychiatric history, relevant personal history—the patient’s current social situation, a mental status examination, and the patient’s risk of suicide (Ministry of Health, 1993). Such assessments are included upon admission to hospital, and are recorded on hospital intake forms.

In the community crisis situation it is not always possible to undertake a full assessment of suicide risk. In such circumstances crisis clinicians still attempt to carry out a rapid and brief lethality assessment, which includes “asking about suicidal ideation, prior suicide attempts, homicidal thoughts, and the feasibility of carrying out suicidal ideation or homicide” (Roberts, 2000, p. 520).

While assessment of lethality requires the clinician to make inquiries of the patient’s suicidality, this does not necessitate asking for a guarantee of safety. However, at least one author suggests that patients who are not able to give reassurance of their safety should be admitted for observation (Morgan, 1981). This suggestion appears to ignore the notion that some patients use the language of suicide to actually gain admission to hospital or achieve other secondary gain (Schwartz, 1979). Admission of these patients is likely to be, in the words of one nurse interviewee “countertherapeutic.” Nevertheless, most nurse participants considered that the refusal of some patients to agree to the NSC effectively forced clinicians to take conservative suicide management decisions. Interviewees...
were concerned that if they ignored the refusal to enter into a NSC, they were likely to be held responsible for any negative outcomes.

Also notable are the accounts of situations where persons at high risk of suicide received less conservative management, based on the existence of a NSC. There is reason to suspect that other interviewees did not recognize these situations, as the very presence of the NSC indicated that suicidality had been reduced. This suggests that the presence of the NSC may detrimentally alter suicide management decisions in some instances.

Clinician’s confidence in the ability of the NSC to provide accurate diagnostic information appears to be misplaced. Crisis clinicians work in an environment where assessment and subsequent decisions must be made in changing circumstances, without the luxury of time to fully consider all decisions (Murdach, 1987). Within these constraints the clinician often has only the information provided by the clinical interview on which to make an assessment of risk, and therefore on which to base decisions of future management of the suicidal person. Eddins and Jones (1994) assert that “the primary goal of risk assessment is to develop a shared understanding of the forces underlying the patient’s suicidality” (p. 172). To do this, however, the clinician must make decisions based upon the information offered by the patient, which, as has been shown, is not always reliable in this situation. To utilize the NSC in order to gather information, when the tool itself may encourage patients to give false information, may be an unwise practice.

It is difficult to interpret the disparity in nurse and patient experiences in any conclusive way. Rapport is by nature subjective, and the complex circumstances of the emergency situation are likely to impinge on efforts to build therapeutic relationships (Murdach, 1987). Any number of factors in the interviews may have contributed to the reasons for the differing experiences of the NSC. To establish these factors would require further extensive research.

The sense of coercion felt by the patients must seriously challenge the ethical integrity of the NSC. If the tool is to be used at all, steps must be taken to ensure that patients enter into it voluntarily. It is doubtful, however, that this “voluntariness” can be assured with vulnerable patients in urgent situations.

Expanded research into the effects of the use of NSCs is indicated. In particular, future research needs to have increased numbers of patient interviewees. This would allow closer examination of the variables that may influence their experience such as length of time as a patient in the mental health system, specific mental health diagnosis, previous experiences of crisis intervention, existing relationships with clinicians in the mental health system, and other demographic differences.

### Conclusion

The exploratory nature of this research means that care must be taken when determining implications for practice. Nevertheless, there are indications that the use of NSCs in community crisis situations may bring about deleterious results. Given the dearth of evidence that the tool is even efficacious at preventing suicide, clinicians should be aware of these dangers and consider them before using NSCs.

### References


---

**Brief Treatment and Crisis Intervention / 2:3 Fall 2002**

---


