

SUICIDE PREVENTION: CRITICAL ELEMENTS FOR MANAGING SUICIDAL CLIENTS AND COUNSELOR LIABILITY WITHOUT THE USE OF A NO-SUICIDE CONTRACT

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Despite its entrenchment as a standard of practice, no-suicide contracts fail to achieve their purpose as an effective part of treatment or as an effective method of inoculating counselors against potential lawsuits should a client commit suicide. Critical elements for managing suicidal clients and counselor liability without reliance on the no-suicide contract are presented. Therapeutic considerations include evaluating clients to determine (a) no referral for hospitalization needed, (b) referral for voluntary hospitalization, or (c) referral for involuntary hospitalization.

Counselors often face a dilemma when working with moderately to severely depressed clients regarding obtaining commitments from these clients that suicide will not be an option. Counselors in the early 1970s interviewed clients asking questions to ascertain suicidal intent, and mental health nurses in the 1980s elicited promises from patients that they would not engage in suicide. The history of suicide contracting is reviewed. The incorporation of suicide contracting into current clinical practices is examined. Legal ramifications and therapeutic considerations of suicide contracts are described. Advantages and disadvantages of their use are examined. A comprehensive approach to treatment is provided, and decision-making guidelines are offered.

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Emergence of No-Suicide Contracts

No-suicide contracts emerged from an assessment tool for use with moderately to severely depressed clients even though as a general rule, all threats were to be taken seriously during initial contacts with a client whether they appeared to be manipulative or intentional gestures. A client's references to suicide were never to be readily dismissed nor should a suicidal client be asked to refrain from committing suicide (Ewalt, 1967).

A study for assessing suicidal risk was conducted by Drye, Goulding, and Goulding in 1973. For this study, they surveyed 31 counselors who reported on 609 clients, 266 of whom were considered seriously suicidal. Out of the 266 seriously suicidal clients, 24 suicides or serious attempts at suicide were reported where their method for assessment was not used and four deaths where it was used. The method described required that when the counselor became aware of the client's suicidal ideation the client was asked to repeat the following, "No matter what happens, I will not kill myself, accidentally or on purpose, at any time" (p. 172). The client was then asked to discuss his reaction to the statement. If the client agreed with this statement, offering no qualification verbally or nonverbally, the counselor could dismiss suicide as a clinical concern. If, however, the client objected to the statement or altered it in any way, that client was considered at risk for suicide. No-suicide contracts slowly but surely became a standard of practice for dealing with suicidal clients even though the authors never intended for a statement by the client not to commit suicide to be used as a contract between client and counselor. Their intention was that the statement be used for assessment purposes only.

Although this study had serious flaws, it became the turning point in clinical decision making and became the historical foundation for no-suicide contracting in a variety of health professions (Stanford, Goetz, & Bloom, 1994). This study received criticism because of its failure to provide information on the reliability or validity of the questionnaire used, gave no information regarding the time span of the study, and gave little information on how participants were selected (Davidson, Wagner, & Range, 1995). It was observed that suicides were not differentiated from attempts, and because of inadequate information, statistical analysis was not possible.

The nursing profession first accepted no-suicide contracting into clinical practice in 1981. Several prominent nurse authors endorsed suicide contracting, although it had not been tested with any scientific rigor. Despite the limited endorsements, nurses working in crisis or inpatient settings found that the use of no-suicide contracts began to have its own definition and ramifications (Egan, 1997).

In 1988, no-suicide contracting further found its way into family practice medicine despite a continued lack of scientific evidence to support its usefulness (Stanford et al., 1994). Soon thereafter, no-suicide contracting received widespread acceptance in mental health literature and practice (Weiss, 2001). One possible explanation for this ready acceptance is that suicide is a culturally constructed act and has much to do with a shared understanding about the meaning of death (Counts, 1991). In the United States, suicide is seen as a negative act; thus the stage was set for the acceptance of any intervention that might possibly save lives.

A survey of 112 psychiatrists and psychologists revealed that there was a general belief in the effectiveness of a no-suicide contract that led counselors to its use as opposed to any research data that supported its effectiveness, and counselors failed to be trained in the use of no-suicide contracting (Miller, Jacobs, & Gutheil, 1998). A counselor should not rely solely on a no-suicide contract, as implied by the statement that, "If a promise or contract were sufficient, we'd be unnecessary" (Reid, 1998, p. 318).

No-suicide contracts continue to be widely advocated as a therapeutic strategy, yet no empirical evidence exists to support the effectiveness of such contracts used by primary care physicians. However, these contracts can be useful in conjunction with a comprehensive assessment with patients who are at high risk for suicide. The physician's role in identifying these individuals and preventing self-harm is crucial because primary care physicians more often are the first and most frequented professionals seen by suicidal individuals (Kelly & Knudson, 2000; Maltzberger, 1991). This applies not only to the United States but in other countries as well (Pfaff, Acres, & Wilson, 1999; Takahashi, 1993).

No-suicide contracts were evaluated by 112 undergraduate college students who rank-ordered factors that might decrease

suicidal desire, and they rated no-suicide contracts the least effective of seven factors such as medication, stronger coping skills, and the quality of the relationship between the client and the counselor; these college students were more positive about no-suicide contracts if they were detailed and specific. However, such contracts were viewed by them as being somewhat valuable rather than harmful or merely an administrative detail that the therapist must complete (Buelow & Range, 2001).

Managing suicidal situations is a great clinical challenge. Because a high percentage of those who complete suicide have diagnosable psychiatric disorders, it is critical to pay careful attention to clinical diagnoses (Robins, Murphy, Wilkinson, Gassner, & Kayes, 1996; Weiss 2001). Limitations exist with the use of no-suicide contracts, and without formal training in their use greater difficulty is likely to be encountered by clinicians and primary care physicians. More training and guidelines should be implemented for both mental health professionals and primary care physicians (Maltsberger, 1991; Pfaff et al., 1999; Takahashi, 1993), and these professionals should be cautious about using or promoting the use of any intervention whose efficacy and utility has yet to be empirically demonstrated. Therefore, no-suicide contracting without a thorough assessment of risk is inadvisable (Goldblatt, 1994; Weiss, 2001).

In a review of the medical records of 650 discharged psychiatric patients, there was no evidence that contracting prevented self-harm behaviors (Drew, 2001). Furthermore, professionals in many countries do not include the use of a no-suicide contract as a preventive measure (Hawton & van Heeringen, 2000). Nevertheless, more research is needed to determine the effectiveness of no-suicide contracts in preventing suicide. Mental health professionals have limited training opportunities in the use of no-suicide contracts including how and when to use them. In addition, when making clinical decisions it is unwise to depend too heavily on the no-suicide contract to the exclusion of assessing client stressors and defense mechanisms. Assessing client stressors and defense mechanisms provides a more thorough assessment in making a clinical decision (Goldblatt, 1994; Range et al., 2000). In addition to more training, collaboration between mental health professionals and medical specialists will yield more effective interventions and services (Takahashi, 1993).

Suicide Contracts: Risks of Litigation

The legal liability of professionals and the safety of suicidal clients are concerns of mental health professionals. Counselors should keep abreast of current legal and ethical standards, have a current policy for handling crisis clients, maintain clinical competency, ensure accurate and thorough documentation, and develop relevant resources such as contact with professional colleagues and state licensing boards (Jobes & Berman, 1993).

Traditional inpatient settings historically have had a definite protocol for dealing with suicidal clients, whereas outpatient settings have not. Over time, outpatient counselors have become increasingly subject to litigation making it necessary to establish similar protocols. However mental health professionals have continued to be inadequately trained in suicidology, which includes the practices of foreseeability and reasonable care. *Foreseeability* is defined as a comprehensive and reasonable assessment of risk; whereas *reasonable care* involves developing a comprehensive treatment plan and the timely implementation of interventions based on the assessment of risk, or foreseeability. The counselor makes decisions for treatment based on known risk factors as well as mental status and diagnosis. One may not be able to accurately predict a client's actions but failure to assess risk and make sound judgments sets the counselor up as a target of litigation (Jobes & Berman, 1993; Maltzberger, 1991).

Courts focus on foreseeability and causation when examining whether the counselor could have predicted harm by recognizing the risk presented by the client, and understanding the degree to which the counselor sought to protect the client from self-harm. It is the responsibility of the counselor to be thorough in the assessment in order to anticipate possible harm. Therefore, if the assessment indicates that the client is a danger to self, it is imperative that alternative steps be taken as opposed to the use of a no-suicide contract (Bongar, 1991).

Because bereaved survivors are hurt, grieving their losses, perhaps feeling guilty, and often seeking recompense for their loss through a claim of negligence, the number of lawsuits continues to rise. For quite some time, hospitals have been the primary targets of lawsuits due to the large sums that frequently have been awarded to plaintiffs. However, counselors in contemporary

practice are seeing a dramatic increase in the number of malpractice claims brought against those who have treated clients on an outpatient basis who committed suicide. Therefore, mental health professionals must provide competent care of suicidal clients and at the same time protect themselves from litigation (Jobes & Berman, 1993).

A no-suicide contract was never intended to be used as a contract for life but rather as part of the assessment for lethality (Drye et al., 1973). One error by counselors is the belief that the use of a no-suicide contract protects them from liability should a client commit suicide. A more appropriate response to a suicidal client is to use an aggressive assessment, which often includes a referral for hospitalization (Clark & Kerkhof, 1993; Goldblatt, 1994). In the absence of an aggressive assessment, the client is placed at a greater risk of suicide and the counselor for litigation (Pfaff et al., 1999).

The use of a no-suicide contract may be a counselor's attempt to manage the anxiety associated with treating suicidal clients; however, the use of the no-suicide contract does not exonerate the counselor of malpractice liability should the client commit suicide. For protection against liability, an ongoing assessment of suicide risk is imperative. A no-suicide contract is an event, whereas assessment of a client is a process. A no-suicide contract does not meet the criteria for a legally binding contract thus leaving the counselor who relies solely on the use of a no-suicide contract vulnerable to lawsuits (Simon, 1999). Counselors are better prepared to face a lawsuit when they can verify that they thoroughly assessed for lethality and provided appropriate interventions rather than relied on a no-suicide contract (Miller, 1999).

It is difficult to formulate treatment plans and models of treatment because suicidal behavior cannot be reliably predicted in any individual case and because counseling with suicidal clients is very complicated and demanding (Maltsberger, 1986; Rudd et al., 1999). A five-step model of reliable interventions that would provide greater safety for the client and less risk of litigation for the outpatient counselor should be used. The five steps are (a) knowing current laws and ethical standards, (b) developing and adhering to written policies and procedures, (c) ensuring that appropriate and current training in suicidology is maintained, (d) providing thorough documentation, and (e) having a network of clinical

resources. This process is cumbersome and time-consuming; therefore, many assessment and documentation forms are available to make the process more manageable for the outpatient counselor (Rudd et al., 1999).

The legal aspects of suicide are complicated and can influence the outcome of litigation based on several factors including (a) the standard of care in a given region, (b) the lawyer's ability to influence juror opinion, (c) the number of experts hired by the plaintiff and defendant to testify, and (d) the experts' ability to influence juror opinion (Jobes & Berman, 1993). Because litigation can be as unpredictable as suicide, it is wise for a counselor to provide maximum protection for a suicidal client, which in turn provides as much protection against litigation as is possible for the counselor.

Counselors have been known to use contracts as a way of relieving their anxieties regarding possible suicide. This is inadvisable from a legal and ethical standpoint because the counselor is relying on a mentally unstable individual who at the time of the agreement may be incapable of making sound judgments. While no-suicide contracts may be helpful in conveying concern for the client, counselors should not rely on the use of no-suicide contracts to prevent suicide (Reid, 1998).

No-Suicide Contract Advantages and Disadvantages

When no-suicide contracts are used by therapists, advantages and disadvantages exist. It is vitally important for the therapists to examine these advantages and disadvantages before making a decision to rely on an intervention strategy that has not been proven to have empirical reliability.

Advantages

One use of a no-suicide contract is to establish guidelines for treatment over a given period of time, and every therapeutic intervention that is part of the treatment plan needs careful documentation, not just the use of a no-suicide contract. Another use of a no-suicide contract is that it emphasizes that the counselor and client have a common goal to keep the client alive, and it expresses counselor concern. In addition, when analyzing treatment options for managing suicidal client risk, the counselor is

encouraged to invite the client to talk about suicidal thoughts and to include a significant other in analyzing treatment options (Maltsberger, 1991; Miller et al., 1998).

The use of a no-suicide contract can be useful in building a therapeutic alliance as well as encouraging clients to take personal responsibility for their actions. Moreover, the no-suicide contract helps to slow down the thought processes of suicidal clients, appeals to their sense of honor, and relieves their concern regarding counselor anxiety (Hipple & Cimboric, 1979; Stanford et al., 1994).

Building a therapeutic alliance is the foundation of successful counseling, and when working with suicidal clients, this remains true (Rudd et al., 1999). When a client is suicidal and the counselor decides that a no-suicide contract is appropriate, the process of working on this agreement together can strengthen the therapeutic alliance because the client perceives the use of the contract as an expression of caring and its use reinforces that suicide is a poor choice (Miller, 1999; Range et al., 2000; Weiss, 2001).

In dealing with suicidal clients, it is imperative to complete a thorough assessment. Every assessment carries the consideration that what may be helpful for one client could be harmful for another. When used appropriately, a no-suicide contract can provide useful diagnostic information in order to determine appropriate treatment. These contracts need to be clear in purpose, specific, and detailed (Buelow & Range, 2001; Range et al., 2000; Weiss, 2001).

Suicidal clients often feel as if their lives are out of control, and the use of a no-suicide contract is a tangible reminder that control is possible. No-suicide contracts can be particularly helpful with clients who have personality disorders because a no-suicide contract may help them feel as if they have more control. A piece of paper may serve as a useful reality check for the psychotic patient (Miller, 1999).

Therapeutic interventions include the acknowledgement that the suicidal client has total control over the suicide decision. This acknowledgement will decrease counselor feelings of frustration, anger, and resentment, which could impair clinical decision making. Other interventions include 24-hour counselor availability, vacation backup, an increase in the frequency of office visits, extended session time, more frequent telephone contacts, having dialogue with the part of the client who wants to stay alive,

enlisting the help and support of family and friends, limiting accessibility of antidepressant medication, and on-going consultation with other professionals (Bongar, 1991).

The time, effort, and commitment that go into a no-suicide contract provide the client the time and space to develop alternate coping and action plans. In addition, a no-suicide contract facilitates the passage through a difficult period while working on negative emotions, difficult circumstances, and various therapeutic issues. Some clients are more willing to work on deeper issues as a result of having had the topic of suicide and a no-suicide contract directly addressed (Davidson et al., 1995; Range et al., 2000; Weiss, 2001).

Disadvantages

It appears that many counselors have focused on the advantages of using a no-suicide contract but have failed to recognize the disadvantages. One such disadvantage is that even though a contract may be used to enhance the therapeutic relationship, a suicidal client may see this gesture as a mechanism for reducing counselor anxiety rather than to actually meet the client's needs. In this case, the suicidal client may sign a no-suicide contract simply to appease the counselor. Notably, another disadvantage is the hidden meaning of the contract as perceived by the client that is likely to discourage client communication regarding his suicidal ideation. The client may conclude that the contract is used only to alleviate counselor discomfort (Miller, 1999).

The therapeutic relationship can be negatively affected should the client, after signing a no-suicide contract, become reluctant to talk about persistent suicidal thoughts. The client may perceive that talking about suicidal thoughts would be interpreted as violating the contract terms. Should this occur, the client is likely to close off further discussion leading to harmful communication barriers, which negatively impact the therapeutic alliance. The suicidal client in this case may also deny continuing thoughts of suicide, which would put the client at further risk (Miller et al., 1998). Unfortunately, it has been reported that some clients believe that unless they sign a no-suicide contract their counseling will be discontinued (Range et al., 2000). This power differential has the potential for negatively affecting the therapeutic relationship.

From a diagnostic perspective, counselors may believe that by securing a no-suicide contract, they have completed an assessment of suicidality. This idea is inaccurate, short-sighted, and legally precarious (Range et al., 2000; Stanford et al., 1994; Weiss, 2001). Securing a signed no-suicide contract may falsely reassure the counselor that the client will not commit suicide thus leading the counselor to pay less attention to the risk involved. Furthermore, it has been observed that some counselors will spend an inordinate amount of time focusing on a no-suicide contract and leave other therapeutic issues unattended (Miller, 1999).

The factors that influence a counselor's decision to use a contract include fear of litigation and the counselor's emotional response to the client. An alternative approach, informed consent, includes candid statements and frank discussions regarding the risk of early death, reduced client autonomy, and potential institutional commitment associated with suicide preoccupation or attempts or both. Effective treatment of suicidal clients requires that the counselor not operate out of the fear of lawsuits and not overvalue the use of a contract as a risk management tool (Miller, 1999). Moreover, in the process of developing a no-suicide contract, it is possible for the client to perceive that the counselor is more concerned about avoiding possible litigation than having genuine therapeutic concern. This perception by the client could negatively affect the therapeutic alliance (Miller et al., 1998; Range et al., 2000; Weiss, 2001).

Every mental health professional is required to provide comprehensive services to clients; failure to do so places the mental health professional at risk for litigation should a suicide occur. A no-suicide contract is not a legal document, and thus it will not provide legal protection against possible litigation (Miller, 1999; Miller et al., 1998; Range et al., 2000; Weiss, 2001). In order for a contract to be legally binding, the parties must be viewed as competent to participate, valuable consideration must be included, mutual obligations must exist, and the contract must not be inconsistent with public policy. The legal community emphasizes that a no-suicide contract does not meet the criteria of a legally binding contract, and using it as a contract could make the counselor legally liable should the counselor neglect incorporating a comprehensive assessment (R. E. Poundstone, personal communication, May 7, 2004).

Critical Elements in Suicide Management

Five elements are critical in working with suicidal clients. When these five critical elements are incorporated into the therapeutic approach, a more protective plan for clients is created, the need for a no-suicide contract is eliminated, and counselors are better protected from litigation. Even though standards of care vary from state to state, when these five critical elements are documented, and a client does commit suicide, it is more likely that a provider will be able to show that a good standard of care was followed.

The first critical element for ensuring client and counselor protection is to complete a thorough assessment of risk. Suicide assessment tasks include identifying risk factors and suicidal ideation (Hawton, 2000; Shea, 2002). It is also critical to adequately assess suicidal intent (Neimeyer & Pfeiffer, 1994). This can be accomplished by selecting one of many available suicide assessment tools, some of which can be purchased or downloaded free of charge from various internet sites (Range et al., 2000). It is recommended that a clinician use a tool that assesses specifically for suicide rather than a tool that assesses for depression. While a depression scale may be helpful in identifying suicidal ideation, it is important for the counselor to use a tool specifically designed to assess suicide intent.

The Suicide Intent Checklist (see the appendix) is designed for easy assessment in surveying for “yes” answers. The more affirmative responses that are given, the greater the likelihood that the client will engage in self-harm. Specifically, if the first four questions are responded to in the affirmative, an immediate referral for hospitalization is advised. The remaining questions continue to survey for affirmative responses providing the counselor with additional clinical information. Ethical codes for mental health professionals are based on doing no harm; therefore, if any of the questions raise concern in the mind of the counselor, consultation or referral or both procedures are necessary. The primary goal is to protect the life of the client. The secondary goal is to protect the practice of the counselor. One of the historical problems with no-suicide contracts is that counselors often rely on them as a first course of action rather than using a formal assessment. A no-suicide contract cannot be substituted for a formal assessment of suicidal intent.

The second critical element to ensure client and counselor protection is to create an appropriate management plan. If the client poses a danger to self, the appropriate plan is to refer for hospitalization. However, if the client has ideation but no intent to engage in self-harm, an appropriate management plan might include (a) ensuring 24-hour availability of services including coverage of vacation and holiday periods; (b) increasing frequency of sessions; (c) extending the session time past the typical 50 minutes; (d) collaborating with the client to bring family members, friends, or other trusted individuals into counseling; (e) ensuring that the treatment plan is updated as needed, referring to a psychiatrist or other physician for clinical evaluation and medication as necessary; (f) following up to determine client compliance and disposition; (g) monitoring medication allocation and use; and (h) establishing a check-in system with the client. Aggressive action and follow-up is necessary throughout the process in order to achieve the best results (Bongar, 1991; Rudd et al., 1999).

The third critical element for ensuring client and counselor protection is to involve family members or significant others (Hawton, 2000). If it is determined that a client may be at risk for suicide, mental health providers are obligated to break confidentiality and involve family or responsible others to help protect the individual. This is best accomplished by collaborating with the client and by remaining sensitive to family issues. Because some clients are opposed to involving significant others as a part of treatment, it is wise to process with clients their concerns regarding this necessity. However, it is the responsibility of the counselor to act in behalf of client safety regardless of the client's preference (Maltsberger, 1986; Shea, 2002). Through informed consent, the client should already be aware that if suicidal issues present, family or friends will become a part of the treatment process.

The fourth critical element for ensuring client and counselor protection is to consult with other professionals. Despite counselor confidence in the treatment plan, conferences with allied professionals can be useful in confirming the appropriateness of the plan. Emotions can run high when dealing with potentially suicidal clients, and it can be helpful to get a more objective assessment of the counselor's intervention strategies. In addition, there are experts in suicidology who are willing to share their expertise in order to facilitate best practices in treating suicidal clients. During

less emotionally charged times, the counselor can take advantage of opportunities to speak with colleagues and/or experts about clinical issues surrounding suicide in order to develop a more extensive repertoire of effective interventions. Another benefit in consulting with other professionals is that the counselor can share personal emotional reactions to the current crisis, counselor burn-out, and countertransference issues (Shea, 2002). Effective counseling sometimes includes the counselor seeking personal counseling either formally or informally.

The fifth critical element for ensuring client and counselor protection is implementation of the plan assuming professional responsibility. All interventions point to the well being of the client, and all actions taken must be documented. Most organizations have a well-defined procedure for dealing with suicidal clients. The wise counselor will stay current regarding guidelines, follow protocol, and consult with organizational administrators (Jobes & Berman, 1993). However, the counselor is required to use good judgment should the protocol or consultation violate ethical standards and best practices.

Documentation of all contacts with other professionals and with the client must be made expeditiously. Regulations and administrators change frequently; therefore the counselor must remain current on appropriate documentation requirements. Effective risk management requires counselors to document information regarding suicidal clients regularly and comprehensively even though time constraints make this difficult. At a minimum, counselors are encouraged to outline risks discussed and treatment options explored and selected, and to indicate that the client was competent to understand the agreed upon treatment plan (Miller, 1999). No doubt the case of the suicidal client takes up a great deal of time and emotions; however, to neglect accurate and thorough documentation of all contacts, amendments, changes, and plans would be detrimental should litigation result from a treatment issue (Jobes & Berman, 1993; Shea, 2002). Equally important is professional competence: knowing the laws and ethical standards, having a written risk-management plan in your practice, remaining current by reading, attending workshops, consulting with other professionals, and being thorough in documentation (Jobes & Berman, 1993).

The benefit of practicing these five critical elements is that the client experiences great emotional and physical protection even when there is no use of a no-suicide contract. The benefit for the counselor is confidence that the approach to the suicidal client is grounded in best practices rather than reliance on or even including a no-suicide contract, which has no empirical evidence as to its effectiveness.

Therapeutic Considerations

Even though no model can fit all situations, having a model for making appropriate clinical decisions can be time-saving and prudent in the managed-care world. Decisions regarding the treatment plan for suicidal clients usually fall into one of three categories (a) no referral needed (see Figure 1), (b) referral needed—voluntary (see Figure 2), and (c) referral needed—involuntary (see Figure 3). With regard to these decision making guidelines, it is noted that a no-suicide contract is excluded. The reason for this clinical decision is that there are more appropriate and safer options for the client in place of a no-suicide contract. Based on the categories mentioned, the flowcharts were created to help counselors make critical decisions expeditiously without using a no-suicide contract yet providing thorough and comprehensive care.

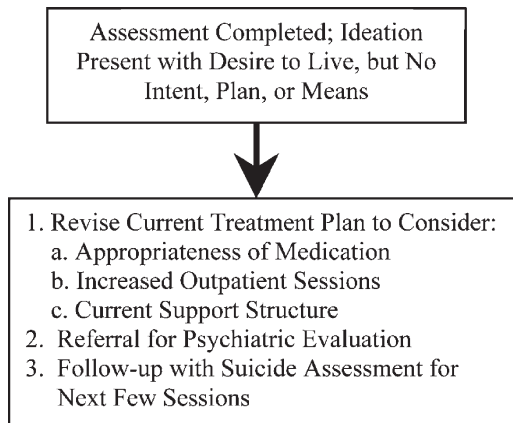


FIGURE 1 No Referral Needed

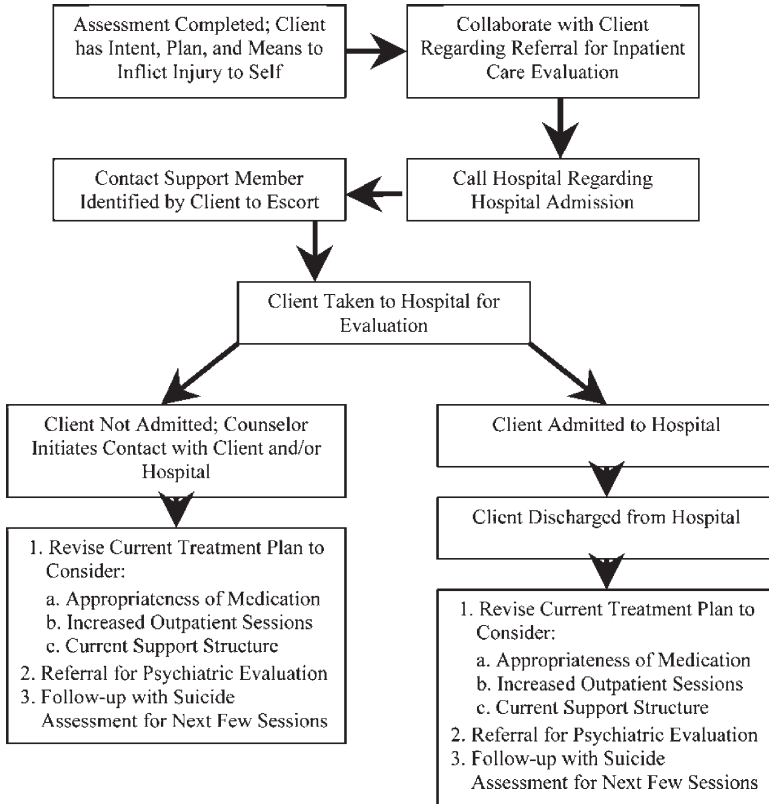


FIGURE 2 Referral Needed: Voluntary

Conclusion

Consistently it has been noted that there is no evidence to support the effectiveness of no-suicide contracts. From the beginning of their use, no-suicide contracts were void of any scientific evidence regarding their effectiveness. Most counselors have used no-suicide contracts with the utmost confidence that this practice would help prevent suicide; however, the fact that this practice was used and the client did not commit suicide does not implicitly mean that no-suicide contracts are effective. No empirical data exist to support their effectiveness. Therefore, the salient question is: Why do counselors continue to use a no-suicide contract when there is no empirical evidence to support its effectiveness in preventing

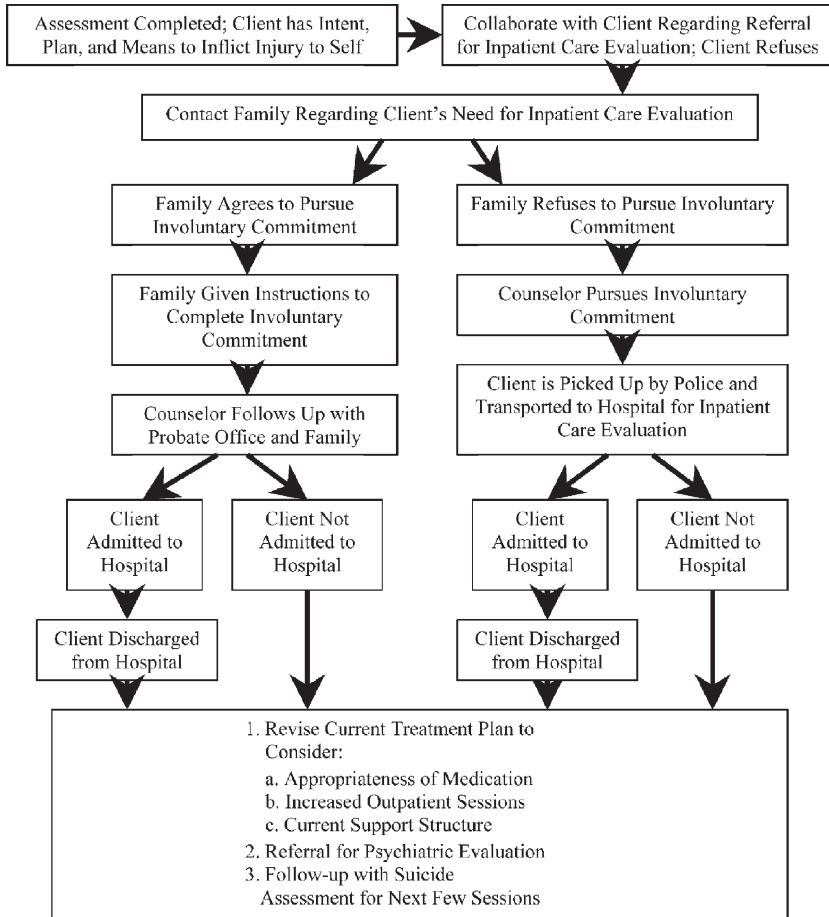


FIGURE 3 Referral Needed: Involuntary

suicide and when the use of a no-suicide contract puts the client at life risk and the counselor at legal risk? There are no empirical data to support the use of no-suicide contracts. Further research could be useful in assisting counselors to fulfill the do no harm principle in the management of suicidal clients.

A research recommendation for the future is to assess whether clients who have actually signed a no-suicide contract believe that it was helpful in averting suicide. Because no empirical evidence exists to demonstrate the effectiveness of no-suicide contracts in preventing suicide, more research is indicated. Another

recommendation would be to compare suicidal clients from the following two groups: counselors who use no-suicide contracts as a standard of practice, and counselors who do not use no-suicide contracts as a standard of practice. It is reasonable to assume that suicides will occur in both groups; however, research of this nature could lead to the cessation of a practice that has never been empirically validated as useful in preventing suicide.

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Appendix: Suicide Intent Checklist

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| 1. Does the client express suicidal ideation? | Yes | No |
| 2. Does the client have a plan? | Yes | No |
| 3. Has the client identified a means? | Yes | No |
| 4. Does the client have access to the means? | Yes | No |
| (if "Yes" to Questions 1 through 4, a definite referral for hospitalization is indicated; however, continuing this assessment will provide more information regarding the client's situation.) | | |
| 5. Has the client expressed a strong desire to die? | Yes | No |
| 6. Does the client have no fear of dying? | Yes | No |
| 7. Does the client use alcohol or drugs? | Yes | No |
| 8. Is there a family history of suicide? | Yes | No |
| 9. Has the client made prior attempts? | Yes | No |
| 10. Does the client have an ineffective support system? | Yes | No |
| 11. Does the client omit references to the future? | Yes | No |
| 12. Is the client experiencing disorganized thoughts? | Yes | No |
| 13. Is the client experiencing hallucinations? | Yes | No |
| 14. Has the client experienced any recent personal losses? | Yes | No |
| 15. Has the client recently been diagnosed with physical illness? | Yes | No |
| 16. Is the client experiencing guilt, blame, or shame for personal behaviors? | Yes | No |
| 17. Has the client made any preparation for death? (i.e., giving away personal items, making a will, writing a good-bye letter) | Yes | No |

Mental health ethical codes dictate that clinical decisions be based on doing no harm. Therefore, if any of the above questions raise concern in the mind of the counselor, consultation and/or referral would be indicated.