

No Harm Contracts and Suicide Prevention

“No Harm Contracts” are known by many different names including “Safety Contract” “Contract For Safety,” “No Suicide Contract” etc. They may be either written or verbal with the common feature being that the client promises not to hurt or kill themselves. Other components may include a specific duration or period of time and an agreement to take certain actions such as calling a crisis line or contacting the therapist prior to hurting oneself.

The origins of these contracts are widely attributed to an article by Drye, Goulding and Goulding from 1973. In tracing the historical progression of this trend, Marcia Goin of the American Psychiatric Association notes that the initial article focused on detailed questions which were intended to elicit specific responses from a patient about their current thoughts and future risk of suicide. As such, the technique was intended to monitor rather than *control* an individual’s suicidality. The original article never mentions the concept of contracting for safety. However, according to Goin, future writing on the subject evolved into the no harm contract.

By the mid 1980’s no harm contracts were increasingly prevalent as a suicide prevention tool in outpatient, inpatient and residential settings. Interestingly, few people seemed to question how an individual whose thinking was so impaired that they were contemplating suicide could enter into a contract, nor did they seem concerned about the reliability of an individual who was on the verge of taking their own life. Even more disturbing was that no harm contracts were frequently used by organizations that had staff with no or limited clinical and/or risk assessment training. At that time, I was fortunate to work for a community mental health center where the medical director had stated in no uncertain terms that anyone caught using a no harm contract would have their job on the line unless they also had a full and detailed risk assessment to back it up.

When NAMI NH’s Frameworks Suicide Prevention Project was working to develop suicide prevention and intervention protocols there was heated discussion in the mental health provider workgroup regarding recommendations about no harm contracts inclusion as a best practice. While there was general consensus that these contracts by themselves neither prevented suicide nor protected the therapist against civil liability, much discussion focused on their use as an important component of risk assessment and as a way of developing a therapeutic alliance with the client. Ultimately the decision was to include no harm contracts as part of a full risk assessment with a clear warning about their limitations.

One of the most troubling aspects of doing suicide prevention work the past few years is to see the continued practice of using no harm contracts as a stand alone intervention for dealing with someone who is suicidal. Although the good news is that most clinicians are aware of its limitations and if they use it at all they do so as part of a comprehensive risk assessment, the bad news is that it continues to be commonly used in some settings, often by people with little or no clinical training, as the sole determinant of an individual’s risk for suicide. While knowing if someone refuses to sign a no harm contract would be an

important piece of information to have, their effectiveness in preventing suicide may end there.

A study of no harm contracts in clinical practice by Kroll published in the American Journal of Psychiatry in 2000 was unable to determine any statistical significance of their effectiveness. A more recent article by Lewis in the Feb. 2007 Suicide and Life Threatening Behavior concluded: *“The existing research does not support the use of such contracts as a method for preventing suicide, nor for protecting clinicians from malpractice litigation in the event of a client suicide.”* The latter point is also supported by recent large dollar settlements in wrongful death suits where no harm contracts were used.

This article is written in the hopes that individuals or organizations which utilize no harm contracts are fully aware of their limitations and use them only as part of a full risk assessment by a qualified professional. We all have a responsibility in preventing suicide. Please consider passing this on to someone who might benefit from knowing more about the limits of no harm contracts.

This is the sixth in a series of articles for the NH NASW newsletter on suicide prevention. Previous articles can be viewed in the suicide prevention/resource and support section of the NAMI NH website www.naminh.org Future articles in this series will include: Clinicians as Survivors and Postvention (activities to reduce risk and promote healing after a suicide death). For more information contact Ken Norton 225-5359 or knorton@naminh.org