

The No Harm Contract in the Emergency Assessment of Suicidal Risk

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2. Age

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Background: The No Harm Contract has been widely accepted in clinical practice, yet there is no broad consensus as to its value. This paper examines the contract and offers recommendations for its use as well as cautions about its misuse.

Method: After a literature review, the No Harm Contract is examined from diagnostic, therapeutic, and medicolegal perspectives.

Results: Diagnostically, the No Harm Contract can be used to assess the nature and severity of a patient's suicidality, uncover specific troubling issues precipitating suicidal thoughts, and evaluate the patient's competency to contract. Therapeutically, the contract affords an opportunity to initiate a therapeutic alliance, establish the limits of the psychotherapeutic framework, and reduce both patient and clinician anxiety. Medicolegally, the contract is not legally binding and grants no suicide malpractice suit protection.

Conclusion: Although the No Harm Contract is a frequently used clinical tool that can provide diagnostic information and therapeutic advantage, it can also short-circuit comprehensive suicidal assessment and disposition decisions.

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Because the evaluation and disposition of suicidal patients are critical aspects of psychiatric care, the clinician must carefully assess techniques frequently employed in this type of crisis intervention. One such technique, the No Harm Contract (NHC; also called the No Suicide Contract by some practitioners), is widely used by psychiatrists and other mental health professionals, by hospital emergency departments, and in inpatient and outpatient settings.

Operationally, the NHC is a verbal or written agreement, initiated by the therapist, in which the suicidal pa-

tient is asked to agree not to harm or kill herself or himself for a particular period of time. The patient may (1) agree with this proposal verbally or by signing a written statement, (2) suggest modifications, (3) refuse compliance, or (4) choose not to answer.

The following example illustrates one application of the NHC. City police brought a 19-year-old white man for diagnosis and treatment to our university hospital psychiatric emergency service, staffed by first- and second-year psychiatric residents, psychiatric nurse practitioners, and a staff psychiatrist. The patient, who said to the emergency room triage nurse, "I feel like I want to kill myself," was a disheveled "rabble-rouser appearing" man who smelled of alcohol. He was described as intoxicated; he stated that he was depressed and had sustained a self-inflicted finger laceration earlier that day, but denied suicidal ideation (discounting his earlier statement) during the evaluation by the psychiatric clinician. Judgment and insight were fair; diagnostic impressions included alcohol abuse/dependence, drug abuse/dependence, adjustment disorder with depressed mood, and probable borderline/antisocial traits. Past psychiatric history was significant for hospitalizations for suicidal and homicidal ideations, multiple suicide gestures, alcoholism since age 11 years, and recent use of LSD, amphetamines, cocaine, and marijuana.

The patient agreed to an NHC, which included the recommendation that he enter a local detoxification center and return to the hospital "if unable to keep the contract."

Review of this case as part of the ongoing teaching program raised concerns about the use of the NHC and prompted its inclusion in our Psychiatric Morbidity and Mortality Conference.¹ The ensuing discussion led us to review the available literature concerning the history and use of the NHC and to evaluate its use by our staff.

This paper describes the results of this review and evaluation and offers suggestions for the appropriate use of the NHC during emergency psychiatric intervention.

METHOD

To identify relevant literature, we initiated a MEDLINE search of the terms *suicide* and *contract* (abstract words) and *suicide prevention and control* (MeSH headings). After a further manual search of the

Index Medicus,² a total of 24 articles were identified from all sources as relevant.

For this review, we first describe and then evaluate the utility and contraindications of the NHC from historical, diagnostic, therapeutic, and medicolegal perspectives.

HISTORICAL PERSPECTIVES

We found contracts with suicidal patients first described in the psychiatric literature in 1967 when Ewalt stated that "under no circumstances should a suicidal patient be asked to promise not to commit suicide."^{3(p1183)}

In 1973 Drye et al.⁴ presented data intended to support and encourage the use of a specific no harm contract. They felt that the NHC provided the evaluator with a quick method to assess risk in suicidal patients. Such patients were asked to repeat the following: "No matter what happens, I will not kill myself, accidentally or on purpose, at any time." The patient was then asked to report on his or her internal responses to this statement. "If the patient reports a feeling of confidence in the statement, with no direct or indirect qualifications...the evaluator may dismiss suicide as a management problem." If the patient objected or qualified the statement about suicide, he or she was felt to be at risk.

Drye et al.⁴ also gave the results of a survey of 31 therapists who reported on 609 patients, 266 of whom were considered seriously suicidal. The authors listed 20 suicides or serious attempts at suicide where the technique was not used, and 4 deaths where it was (1 death by suicide was outside of the time period contracted, 1 patient had organic brain disease, 1 death was accidental, and 1 death resulted from an overdose of drugs in combination with alcohol). Because of inadequate information, statistical analysis of these data was not possible. This report was nevertheless pivotal in the historical acceptance of the NHC, and use of the contract eventually found its way into psychotherapy, nursing, and primary care literature.

In 1979, Hipple and Cimboric⁵ described the use of the NHC in a book focused on helping counselors deal with suicide. In the same year, Goulding and Goulding,⁶ in their book on redecision therapy, characterized suicide contracts as a high priority tool for dealing with suicidal patients.

By the 1980s the concept of the NHC, or the no suicide contract, seemed to have become firmly established in the literature with minimal empirical base. In 1980, in an article on diagnostic and treatment aspects of the suicidal patient, Stone⁷ described the "written pledge" as an aid to building the therapeutic alliance and nullifying the possibility of suicide. The no suicide contract was introduced into the nursing literature by Twiname in 1981.⁸ Also in the nursing literature, Neville and Barnes,⁹ using

the same statement as Drye and colleagues, seconded the negotiation of a no suicide contract as a suicide-risk assessment tool. Getz et al.¹⁰ described the use of the no suicide contracts in relation to brief counseling of suicidal patients. Assey¹¹ wrote a book chapter dealing entirely with the NHC. Others described contracts in relation to the treatment of borderline patients,^{12,13} chronically suicidal women,¹⁴ and a hospitalized suicidal schizophrenic man.¹⁵ The concept of the NHC was also introduced into family practice literature in 1988.¹⁶

Reaction to the widespread appeal and apparent use of the NHC appeared recently in the emergency and forensic psychiatry literature. Hillard,¹⁷ in a manual of clinical psychiatric emergencies, called no suicide contracts "controversial." Simon¹⁸ reviewed both the clinical and legal aspects of the use of the NHC and pointed out the difference between the NHC and a legally binding contract. Finally, Gutheil¹⁹ described the no suicide contract as a concept in danger of taking on a life of its own.

① DIAGNOSTIC, ② THERAPEUTIC, AND ③ MEDICOLEGAL PERSPECTIVES

Therapeutic contracting with patients who exhibit mental or emotional problems has been addressed in the literature from many perspectives. Contracts have been cited as a basic social concept that contain negotiation, reciprocal accountability, and explicitness as critical characteristics.²⁰ Clinically, contracts have been described as enabling psychiatrists to "crystallize and exploit" the intervention process.²⁰ To enhance compliance with contracts, contingency planning, reinforcement, and continued active involvement have been used.⁵ For example, in crisis intervention the term *contract* identifies a communication of mutual expectations as part of an effort to avoid expectations based in fantasy.²¹

The use of a specific NHC with suicidal patients recapitulates the view of a contract as communication having broad social meaning. Because the NHC has found its way into the literature of social workers, nurses, psychiatrists, and family practice physicians, its use as an explicit tool for clinicians must be more closely examined. To identify areas in which the NHC is of clinical usefulness, we have chosen to distinguish between diagnostic, therapeutic, and medicolegal perspectives and to examine each group separately.

① Diagnostic Perspective

It appears that the use of the NHC for diagnostic purposes can be fruitful. In an emergency room setting where a thorough psychodiagnostic evaluation can be quite challenging, the NHC can complement an assessment of the nature and severity of a patient's suicidality. A patient's reply to a request and commitment to remain

safe may yield useful diagnostic information, both in its verbal content (whether or not a patient will make such a commitment) and in the affect and body language in which the reply is given.⁶ For example, a patient may confidently agree to such a contract and discuss his or her feelings about leaving dependent children or other loved ones behind or describe guilt from defying strong religious beliefs regarding suicide, with apparently sincere relatedness and appropriate affect. Another patient may quickly agree to an NHC but appear to be more focused on leaving the emergency room.

Some authors contend that specific responses can be used to determine suicidal risk.^{4,8,9,22} Others emphasize the utility of the NHC for uncovering specific troubling issues that precipitated suicidal thoughts, thereby providing insight to the clinician into the severity or reversibility of the precipitating stressors.^{5,21} The NHC can also be used to assess the patient's ability to participate in a contract, which may influence the need for hospitalization.⁶ From these reports, it appears that the NHC has been used as a diagnostic tool to successfully explore aspects of suicidality.

Therapeutic Perspective

The use of the NHC as a therapeutic tool influences alliance and relationship issues, effects on the patient, and effects on the clinician. Many authors have postulated therapeutic value when the NHC is used to initiate therapeutic alliance.^{7,13,16,18,23} Frequently the clinician has no prior experience with the suicidal patient. If the NHC is presented as an open expression of caring, this beginning alliance could be strengthened.¹¹ When a psychotherapeutic relationship is being initiated, the NHC can be employed to establish clear limits of the psychotherapeutic framework.^{12,13} Critically important is the clinician's ability to allow the patient an appropriate level of personal responsibility for his or her actions.^{4,5} The NHC can also help support the patient's autonomy by offering reciprocal accountability.^{12,20} Ultimately, the clinician attempts to balance assignment of responsibility by evaluating the risk of regression and of institutional dependence (if the patient is hospitalized) against the risk of suicide.¹⁴

Therapeutic effects of the NHC on the patient have also been considered. These include the opportunity for patients to reflect on their suicidal thoughts in order to determine their own suicidal risk, reduce their anxiety,⁴ and avoid confusion.²¹ The NHC also has the potential to improve the intervention process by "slowing thought processes leading to clearer thinking,"⁵ to change the emotional state of the patient,⁶ and to appeal to the patient's sense of honor.⁷ For some patients, there may be an immediate relief of despair by their being able to contract for safety in a limited time frame.⁶ The NHC may function as a behavioral manipulation that allows

the patient enough time to intellectually and emotionally understand the meaning and significance of his or her choices.¹⁰ In patients who resist participation in the contract, confrontation and clarification of this resistance can be explored.¹²

The NHC may also be therapeutic for the clinician. When the clinician is anxious about discussing the patient's intent to harm, endanger, or kill himself or herself, the NHC may afford a mechanism whereby the clinician can empathize with the patient's self-destructive intentions. This may relieve some of the clinician's anxiety. It may also relieve the patient's anxiety about suicidal thoughts and observed anxiety in the clinician.¹⁸ By providing an instrument to aid in evaluating these challenging cases, a clinician may feel better able to objectively assist the suicidal patient. An NHC may facilitate recognition of the reciprocal nature of responsibility in suicide assessment and make evaluation and resolution of the crisis a shared burden. Establishing such a therapeutic framework with an NHC may also facilitate the management of countertransference.¹³ In many characterologically impaired patients, the assessment can be influenced by the clinician's reaction to the patient's projected negative affect. Acknowledgment of the countertransference to the patient's primitive defenses may promote objectivity.

Medicolegal Perspective

Medicolegal implications of the NHC have received more recent attention. The therapeutic potential of the NHC is lessened if it "falsely eases the therapist's concern and lowers vigilance without affecting the patient's suicidal intent."²³ In addition, the legal connotation of "contract" has often misled clinicians in regard to its potential for liability protection. First, these contracts are not legally binding. Second, as clinical interventions, they may afford little protection for the clinician in a suicide malpractice suit.^{13,17-19,23}

Simon²³ described four reasons why the NHC is not a legal contract: (1) the patient may not meet threshold legal criteria necessary for being viewed as competent to participate in the formation of an NHC; (2) no "valuable consideration" is exchanged; (3) there is no mutual obligation, beyond that already implied in the patient-physician care contract; and (4) an "exculpatory clause" protecting the physician from liability would contravene public policy.

The question of the patient's competence is an important consideration. Informed consent is based on the patient's being competent to understand the risks and benefits of alternative treatments, including the question of hospitalization versus outpatient care. In many mental health settings, the NHC is used with a patient who a court might find incompetent to provide informed consent regarding his or her treatment options. Therefore,

Table 1. Recommendations Regarding Use of No Harm Contracts

Potential uses
Explore suicidality
Initiate therapeutic alliance
Establish therapeutic framework
Potential misuses
Allow inappropriate disposition
Replace complete suicidal evaluation
Replace comprehensive treatment planning
Prevent loss from malpractice suit
Inappropriately reassure patient and staff

competence should be clearly addressed in the medical record. Assessing competency, evaluating risk factors for suicide, and assigning responsibility for potential suicidal behavior must be part of the comprehensive clinical evaluation of the suicidal patient.

DISCUSSION

* We found no studies of NHC outcomes that meet criteria for scientific research design. We reviewed only one NHC study that attempted to provide empirical data, but it had serious methodological flaws.⁴ Although there is no real empirical basis on which to evaluate the NHC, intuitive reasoning does support the ideas expressed by several authors that the NHC could appropriately be used to obtain diagnostic information regarding the patient's suicidal intentions. Similar reasoning may support the NHC's therapeutic use to aid in the initiation of the therapeutic alliance, to define a psychotherapeutic framework, to assist the patient's self-measure of suicidality, and to reduce anxiety in both the patient and clinician. It is clear that the NHC cannot be viewed as a true contract offering legal protection from a malpractice suit. The literature provides us with multiple reasons why the NHC should be viewed only as a component of a thorough suicidal assessment. When an NHC is used, the documentation should show a thorough diagnostic assessment, thorough suicidal risk factor analysis, and risk-benefit analysis of hospitalization, along with a measure of the patient's competency. Gutheil and colleagues²⁴ proposed a model in which informed consent and the therapeutic alliance combine to weigh potential dangerousness against the competence of the patient. If the patients are considered fully competent with a low probability of self-harm, they can assume responsibility for their actions and outpatient treatment may be agreed upon. But when incompetency is noted and the clinician considers the assessed danger to be high, risk is assumed and the patient is generally hospitalized, voluntarily or involuntarily.

To summarize, if the NHC is used, it is imperative to understand its potential uses and limitations. These are listed in Table 1. The NHC must be used in the context

of a structured suicidal risk evaluation. Clinicians view the relative importance of the NHC differently. Some consider it the most important variable for assessing suicidal risk; others use it to enhance the therapeutic and diagnostic processes. Some clinicians use it as the concluding and final step of a thorough evaluation, while others choose not to use the NHC in suicidal assessment.

Returning to the case presented in the introduction, suicidal risk included alcohol intoxication, a history of polysubstance abuse, a current self-inflicted injury, past suicide attempts, past psychiatric hospitalizations for suicidal ideation, and depression. These risk factors were documented, but how they influenced the clinician's disposition decision was lacking in the medical record. Instead the report states that the patient agreed to an NHC. The contract was executed even though there were signs that the patient "smelled of alcohol." (There was no documented blood alcohol level.) Also, there was no documented risk-benefit evaluation of hospitalization and no evaluation of competency. How would the courts have viewed the patient's competence to contract?

This case exposed the use of the NHC as likely to undermine a more appropriate approach to the evaluation and disposition of suicidal patients—the NHC might wrongly influence the clinician for or against a decision to hospitalize the patient. If for example, a chronically suicidal patient with low suicidal risk analysis attempted to gain hospital admission and the clinician utilized an NHC, the patient might be unwilling to agree to or sign such a contract. The clinician might then feel "forced" to offer admission. Dispositions based solely on whether or not an NHC was obtained are clearly relying too heavily on its use. After reviewing the history of the NHC and examining it from diagnostic, therapeutic, and medicolegal perspectives, we feel these contracts may assist the clinical evaluation of suicidal patients. But they also have the potential to short-circuit comprehensive assessment of suicidal patients, leading to poorly conceived and potentially dangerous decisions.

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