

The Shift from “No Harm Contracts” to “Safety Plans” for Suicide Prevention and Treatment: A Literature Review

Background

In the past, “no-harm contracts” were a common practice for those involved in suicide prevention and intervention. A contract is a formal agreement by people who have experienced and/or expressed suicidal ideation that they will not harm themselves for a period of time. Usually these are written agreements, but may also be verbal. They have been used by medical providers, mental health professionals and even lay people attempting to keep a suicidal person safe. This type of no-harm contract has been used in the U.S. since 1973. (Norton).

Throughout the 1980’s, use of no-harm contracts became quite common in outpatient, inpatient and residential treatment programs for working with individuals with suicidal ideation (Norton). As many as 70% of psychiatrists and 80% of psychologists have reported using no-harm contracts with their suicidal clients (Joiner et al. 2009). However, despite repeated studies, there has been no evidence to indicate that no-harm contracts actually help prevent suicide. A careful review of the literature by Idaho State University’s Institute of Rural Health showed that no studies demonstrate that contracts are an effective way to prevent suicide, (Kelly and Knudson, 2000) nor did they protect clinicians from liability if a patient died by suicide.(Norton).

New Developments

In contrast to “no-harm contracts” a more recent development in suicide prevention treatment is to focus on “safety plans” also called “crisis plans”. A safety plan is different from a no-harm contract in that, rather than committing to what a person will *not* do, it is a specific commitment for what a person *will* do. Joiner and others refer to this type of intervention as

part of “Commitment to Treatment Statements” (CTS). They say “a key component to the CTS statement is a clearly described crisis plan”. (Joiner et al. 2009) A sample safety/crisis plan (including relaxation techniques, physical activity to reduce stress, how to access supports from family or significant others and the therapist, crisis center and emergency room phone numbers) is contained in *Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals* (SPRC & American Association of Suicidology, Oct. 2008). The suicidal individual also is asked to identify one or more reasons for living as part of the safety plan. SPRC recommends that a CTS form also be used that states what the individual and his/her therapist agree to do as mutual activities in treatment.

The South Dakota Suicide Prevention website supports this concept by saying: *“A safety plan is a prioritized written list of coping strategies and sources of support that patients can use during or preceding suicidal crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that [people] can contact in order to help them lower their imminent risk of suicidal behavior. It is a therapeutic technique that provides patients with something more than just a referral at the completion of suicide risk assessment. By following a pre-determined set of coping strategies, social support activities, and help-seeking behaviors, [people] can determine and employ those strategies that are most effective.”* (SDsuicideprevention.org)

The SPRC in collaboration with the Western Interstate Commission for Higher Education (WICHE) has provided an important resource for doctors called the Suicide Prevention Toolkit for Rural Primary Care, saying: *“The first step in safety planning is to help patients become aware of their own triggers and the cues that signal that a suicidal crisis*

may be developing... The second step in safety planning is to help patients identify and practice coping strategies to help prevent or avert the development of a suicidal crisis. Coping techniques have different effects on different people; therefore, the provider should help the patient think through what really helps him or her feel better... The last step in safety planning addresses the issue of access to lethal means. If the patient has described a specific plan to use lethal means or has experimented with lethal means it is essential to inquire about whether those specific means are available and to eliminate access to them.” (SPRC)

The use of safety planning has been endorsed by the Department of Veterans Affairs (DVA), saying “*comprehensive safety planning is a clinical intervention that can serve as a valuable adjunct to suicide risk assessment*” (DVA 2011). British Columbia notes that: “*Safety planning, a proactive and collaborative process which actively involves the client, is recommended. The primary purpose is to create a plan that the [patient] will utilize during times of suicidal crisis, rather than providing the clinician with a sense of reassurance. Practitioners need to work with the client to ensure that they will feel comfortable carrying out whatever plan is negotiated.*”

British Columbia also indicates that a safety plan is in part: Collaborative in spirit, proactive, individually tailored, capitalizes on existing social support, provides 24-hour backup contacts, and is dynamic and evolving during treatment.

Conclusion

Clearly, safety planning is a more comprehensive approach to suicide prevention than the former no-harm contracts. Safety planning allows people in crisis to focus on specific steps to take or resources to turn to which they previously identify as being meaningful for them. While many studies have been done on the efficacy of no harm contracts because they have been in use for decades, safety plans are a recent development and only anecdotal evidence points

to their success in reducing suicide risk. However, safety planning is an accepted best practice for suicide prevention efforts. Researchers conclude that a safety plan is not a stand-alone tool, but should be part of a comprehensive wrap-around of services including competent screening for risk evaluation and an integrated treatment plan.

References

- Department of Veterans Affairs. Office of Inspector General. March 22, 2011. “Combined Assessment Program Summary Report. Re-Evaluation of Suicide Prevention Safety Plan Practices in Veteran’s Health Administration Facilities.” <http://www.va.gov/oig/CAP/VAOIG-11-01380-128.pdf>
- Government of British Columbia. (2010). “Crisis Response & Safety”. Accessed 6/21/2011 from http://www.mcf.gov.bc.ca/suicide_prevention/crisis.htm
- Joiner, Thomas E., Kimberly A. Van Orden, Tracy K. Witte, M. David Rudd. (2009). “Commitment to Treatment Statements” (CTS) instead of No Harm Contracts”. *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients.* p.92-93
Washington D.C. American Psychological Association.
- Kelly, Katherine T. and Mark P. Knudson. (2000) “Are No-Suicide Contracts Effective in Preventing Suicide in Suicidal Patients Seen by Primary Care Physicians?” *Archives of Family Medicine.* Vol 9. Nov/Dec 2000. Downloaded 6/22/2011 from <http://archfami.ama-assn.org/cgi/reprint/9/10/1119.pdf>
- Norton, Ken. “No Harm Contracts and Suicide Prevention.” www.theconnectproject.org Accessed 6/22/2011 at <http://www.theconnectproject.org/uploads/docs/NoHarmContracts.pdf>
- SDsuicideprevention.org. (2011) “Prevention Basics - Safety Planning” Retrieved 6/19/2011 from <http://www.sdsuicideprevention.org/prevention/index.php?id=77>
- Suicide Prevention Resource Center (SPRC). “Suicide Prevention Toolkit for Rural Primary Care”. Western Interstate Commission for Higher Education (WICHE) Mental Health Program. <http://www.sprc.org/pctoolkit/index.asp>

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